CONFIDENTIAL REGISTRATION FORM

Intake Date #_____

Elizabeth Nyblade, Ph.D.

Full Name _____ Intake Date _____

Social Security Number _____ Sex M F Birthdate _____

Address _____ Employer _____

City/State/Zip _____ Work# _____

Home# _____ Cell # _____ Education: _____

Marital Status (circle one) SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Emergency Contact Name _____ phone#_____

Address _____ City/State/Zip _____

Primary MD Referred by M.D. phone#

Complete by BOTH PARENTS or guardians - if different from client and or client is under 18

Full Name _____ Relationship _____

Social Security Number _____ Sex M F Birthdate _____

Address _____ Employer _____

City/State/Zip _____ Work# _____

Home# _____ Highest Completed or Current Grade _____

Marital Status (circle one) SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Full Name _____ Relationship _____

Social Security Number _____ Sex M F Birthdate _____

Address _____ Employer _____

City/State/Zip _____ Work# _____

Home# _____ Highest Completed or Current Grade _____

Marital Status (circle one) SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Names of Family Members and others living in your home:

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name _____ Birthdate _____ Relationship _____

Name Birthdate Relationship

Person Responsible for payment is:

Name _____ Address _____

Phone# City/State/Zip

Insurance Information (please see financial policies) :

Insurance Company _____ Phone# _____

Subscriber's Name _____ Client's ID# _____

Subscriber's Social Security # Employer

I agree that my insurance <u>may</u> pay Dr. Nyblade directly and that I am responsible for any unpaid balances._____ _____

Signature (Client if 13 years or older) **Signature (Parent/Guardian of a minor client)**