

### Client Registration Form

Client Name:	Gender:	Date of Birth:
Address:	Home Phone No: Work Phone No: Cell Phone No:	Employment/Student Status:
Employer/School Name:	Occupation:	Email:
Is it OK to call you at the #'s listed above about your account? <input type="checkbox"/> Yes <input type="checkbox"/> No		
I would like to receive appointment reminders via: <input type="checkbox"/> Text <input type="checkbox"/> Email		
Who is responsible for this account? (If different than "Self" as listed above, please list Name/Address/Phone)		
In case of an emergency, please call (Name and phone #):		
Whom May We Thank For Referring You To Us?		
Race (optional):	Ethnicity (Optional)	Preferred Language:
<b>Insurance Information</b>		
We cannot guarantee insurance coverage by your insurance carrier. The information below will assist us in determining if some of the expenses are reimbursable by your HMO or insurance carrier. We will ask for a copy of your insurance card and a form of ID at your first appointment.		
Primary Insurance Carrier:	ID#	Group #:
Name of Insured:	Relationship to Insured:	Date of Birth:
Street Address:	Home Phone No	Work Phone No.
City, State, Zip Code:	Employer	
<b>Secondary Insurance Carrier:</b>	ID#	Group #
Name of Insured:	Relationship to Insured:	Date of Birth:
Street Address:	Home Phone No:	Work Phone No:
City, State, Zip Code:	Employer:	