Tom Wilson Counseling Center

REGISTRATION FORM (INSURANCE)

(Please Print)

Today's Date _____/_____/_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (Circle One)
					Single / Mar / Div / Sep / Wid

Is this your legal name?		If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex	
❑ Yes	❑ No			/ /		❑ M	❑ F

Street Address	City	State	ZIP Code	Social Security	Home Phone No.
					( )

Occupation	Employer	Employer Phone No.
		( )

Chose Clinic Because/Referred to Clinic by

Other Family Members Seen Here

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date		Address (if different)	Home Phone No.
	/ /			
Is this person a patient here?	❑ Yes	❑ No		( )

Occupation	Employer	Employer Address	Employer Phone No.

Please indicate primary insurance or Responsible Third Party:

Subscriber's Name	Subscriber's S.S. #	Birth Date	Group #	Policy #	Co-Payment
		/ /			$

Patient's Relationship to Subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No.	Work Phone No.
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Tom Wilson, Licensed Counselor. I understand that I am financially responsible for any balance. I also authorize Tom Wilson Counseling Center or insurance company to release any information required to process my claims.

X		
	PATIENT/GUARDIAN SIGNATURE	DATE