REGISTRATION INFORMATION

Client Name:_____ **Today's Date:**_____

Address:_____ **City:** _____

State:_____ **Zip:**_____ **SS#** _____ ○ **Male** ○ **Female**

Home Ph. #_____ **Cell Ph. #**_____ **Wk Ph. #** _____

Date of Birth_____ ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Email Address: _____

Occupation: _____

Employer: _____

Spouse / Partner Name:_____ **Date of Birth:** _____

Spouse Employed By:_____ **Wk. Ph. #** _____

Responsible Party Name (If client is a minor) _____

Address (if different from client) _____

INSURANCE COVERAGE: ***Would you like us to bill your insurance for you?*** ☐ ***Yes*** ☐ ***No***

Policy Holder's Name:_____ **Date of Birth** _____

SS# _____ **Ins. ID #** _____ **Group #** _____

Address (if different from above)_____ **Home Ph #** _____

City: _____ **State** _____ **Zip** _____ **Wk. Ph. #** _____

Employer: _____

Primary Care Physician:_____ **Phone #** _____

EMERGENGY INFORMATION

In case of emergency, who should be notified? _____

Phone #_____ **Relationship to client:** _____

PAST AND PRESENT HISTORY

Check the boxes which indicate health/illness status for you and your family.

(If couples: Please indicate Yourself with an 'X' and your Partner with an 'O'.)

	Good Health	Poor Health	Died	Depression	Alcohol Abuse	Drug Abuse	Schizophrenia	Bi Polar	Severe Anxiety	Panic Attacks	Obsessive / Compulsive	Hospitalization for Mental Illness	Seizure Disorders	Diabetes	Heart Condition	HIV	High Blood Pressure	T.B.	Migraines	M.S. / M.D	Polio	Other
Patient																						
Father																						
Mother																						
Brothers & Sisters																						
Spouse																						
Children																						
Mother's Mother																						
Mother's Father																						
Father's Mother																						
Father's Father																						

Have you, or anyone close to you, ever attempted or completed suicide in the past 5 years? Yes☐ No☐
If yes, please give the relationship(s) and date(s).

_____

_____

_____

_____

Current Medications & Dosage	Reason(s) for their use:	Prescribing M.D.
______________________	______________________	________________
______________________	______________________	________________
______________________	______________________	________________

Other persons living in the home:

Name	Relationship	How Long?
______________________	______________________	________________
______________________	______________________	________________
______________________	______________________	________________

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with ____________________________________
(Insurance Company)

and assign directly to Dr. Charles Holland all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_________________________________ ___________
Signature of Insured/Guardian Date

* *

I, _____________________________ certify that I am the legally responsible party that is able to consent to medical/psychological treatment for ____________________________________, a child in my custody.

_________________________________ ___________
Signature of Parent/Guardian Date

If you are divorced from the child's other biological parent. Please provide Dr. Holland with a copy of divorce decree or other legal instrument stating your right to independently make such consent decisions.

Thank you for completing the registration information. If there is any other information you would like us to know at this time, please continue on the reverse side and check here ☐.