People Bloom Counseling, PLLC
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CLIENT REGISTRATION FORM

Client Information

Date: _____

Full Name: _____
Last Name First Name M.I.

Home Address: _____
Street Name Apartment/Unit #

_____
City State Zip

Mailing Address (if different from above): _____

_____

Date of Birth: _____ Current Age: _____ Sex: _____
MM/DD/YYYY

Home Phone: _____ Is it okay to leave you a message? _____

Cell Phone: _____ Is it okay to leave you a message? _____

Email Address: _____ Is it okay to contact you via email? _____

Would you like to receive automated appointment reminders? _____

If yes, please indicate preference [circle]: Voicemail Text Email

How did you hear about People Bloom Counseling? _____

Emergency Notification

Emergency Contact Name: _____ Relationship: _____

Phone Number(s): _____

Address: _____

Employment Information

Current Employer: _____

Address: _____

Work Phone: _____ Is it okay to leave you a message? _____

Insurance Information

Insurance Company: _____

Name of Insured: _____ Date of Birth: _____

Address: _____

Subscriber or ID #: _____ Group #: _____

Do you have secondary insurance? _____ If yes, please provide information on back of form

Will someone else other than you be financially responsible for the payment of services? _____

If yes, what is their name? _____ Relationship: _____

Mailing Address: _____

Phone Number: _____

Medical Information

Name of Primary Care Physician: _____ Phone Number: _____

Address: _____

Are you currently under medical care? _____

If yes, please describe: _____

Are you currently taking prescribed medications? _____

If yes, please describe: _____