Ronald O. Powell, PhD
8201 164th Ave Ne, Suite 200
Redmond, WA 98052
425-214-3609

Eastside Cognitive Behavioral Therapy

New Client Registration Form

Client Information

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

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Is it okay to contact you by phone? _____ Is it okay to leave a short message? _____

E-mail: _____ Is it okay to contact you by e-mail to contact you? Y N

Is it okay to text message you to for administrative purposes like scheduling? Y N

Emergency Contact
Name and numbers: _____

Employer Information

Employer: _____

Address: _____

Work Phone: _____May I call you at this number: Y N Leave a message at this number: Y N

Insurance Information

Name of Insured: _____ Date of Birth: _____

Primary Insurance Company: _____

Address: _____

Subscriber or ID# _____ Group #_____

(Please turn over and complete second side)

Name of Insured: _____ Date of Birth: _____

Secondary Insurance Company: _____

Address: _____

Subscriber or ID# _____ Group #_____

Medical and Referral Information

Name of Physician: _____ Approximate Date of Last Physical: _____

Physician's Phone Number: _____By Whom Were you referred: _____

Are you currently taking medications: Y N If yes please describe: _____
_____

Describe any health problems: _____