Behavioral Therapy Center of Austin

Patient Registration Form

Patient Information:

Last Name:_____ First Name:_____ MI:_____ Sex: M / F

Street Address:_____ City / State / Zip:_____

Date of Birth:_____ Parents are: Married / Single / Divorced *(please circle)*

School:_____ Address:_____

Name of Referring Physician:_____Office Phone #:_____ Fax #:_____

Parent/Guardian 1 Information: Relationship to Client *(circle one):* Mother / Father / Other:_____

Last Name:_____ First Name:_____ MI:_____ Sex: M / F

Street Address:_____ City / State / Zip:_____

Email:_____

Cell Ph:_____ Home Ph:_____ Work Ph:_____

SS#:_____ Date of Birth:_____

Parent/Guardian 2 Information: Relationship to Client *(circle one):* Mother / Father / Other:_____

Last Name:_____ First Name:_____ MI:_____ Sex: M / F

Street Address:_____ City / State / Zip:_____

Email:_____

Cell Ph:_____ Home Ph:_____ Work Ph:_____

SS#:_____ Date of Birth:_____

Primary Insurance Information: **Financially Responsible Party:** Parent 1 or Parent 2

Insurance Company Name:_____ Primary Insured *(please circle parent)*: Parent 1 Parent 2

Policy ID #:_____ Policy Group #:_____

Secondary Insurance Information:

Insurance Company Name:_____ Primary Insured *(please circle parent)*: Parent 1 Parent 2

Policy ID #:_____ Policy Group #:_____

Emergency Contact:

Contact Name:_____ Cell Ph:_____ Home Ph:_____

Relationship to Client:_____ Comments:_____

Authorized to release medical or client information to this contact? *(please circle one)* YES or NO

Responsible party signature:_____ Date:_____

- Signature:_____ Date:_____