Angie Lynn, LSCSW, RPT-S
Licensed Specialist Clinical Social Worker
Registered Play Therapist - Supervisor

CLIENT REGISTRATION FORM

Patient Name ____
First Middle Last

Address ____

City ______________________________ State____________________ Zip __________ Birth Date __________

Phone: (Home) ________________________ (Work) ________________________ (Cell)______________________

E-mail address which may be used for appointment reminders ______________________________________

SS# __________________Primary Care Physician ____

Employer ______________________________________ School ______________________________________

Referral Source ____

What concerns do you currently have?

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How would you like to benefit from therapy?

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Responsible Party Information

Responsible Party ____
First Middle Last

Address ____

City ____________________ State ____________________ Zip ____________________

Phone: (Home) ____________________ (Work) ____________________ (Cell) ____________________

Medical Insurance Information

Primary
Subscriber Name ______________________________ SS # ____________________

Employer ______________________________ Subscriber Date of Birth ____________

Address ____

Insurance Carrier Name and Address ____

______________________________Phone Number ____________________

Group Name ________________Group Number ______________ Relationship to Client ____________

Individual Policy Number ________________ Does this plan cover all family members? _______ Yes _______ No

Additional Medical Coverage: _______Yes _______ No

If yes, please complete the following:

Secondary
Subscriber Name ______________________________ SS # ____________________

Employer ______________________________ Subscriber Date of Birth ____________

Address
____

Insurance Carrier Name and Address ____

______________________________Phone Number ____________________

Group Name ________________Group Number ______________ Relationship to Client ____________

Individual Policy Number ________________ Does this plan cover all family members? _______ Yes _______ No

Assignment of Benefits and Release of Information
By my signature, I authorize payment of medical benefits to Angie Lynn, LSCSW, LLC and the release of information to my insurance company in order to process the claim. I am responsible for the balance and payment of co-pays and services which are not reimbursed by insurance.

Signed ______________________________ Date ____________
(Subscriber)

Significant Medical Conditions

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____

Past or Present Medications

____

____

Family Member Information

Name ___________________________________ Age _________ Relationship ________________

Name ___________________________________ Age _________ Relationship ________________

Name ___________________________________ Age _________ Relationship ________________

Name ___________________________________ Age _________ Relationship ________________

Psychiatric Hospitalizations? ________Yes ________No Legal Offenses? ________Yes ________ No

Family History – Medical or Psychiatric

____

____

____

Religious Preference ____

Significant events you feel are relevant to your treatment:

Event	Date
_______________________________________	_____________
_______________________________________	_____________
_______________________________________	_____________

I authorize Angie Lynn, LSCSW, LLC to provide mental health services. I also authorize her to utilize the given e-mail address to communicate regarding appointments.

Signed ____ Date __________
(Patient, or Parent if Minor)