CULTIVATING CHANGE
SPRINGFORTH COUNSELING

NEW CLIENT REGISTRATION FORM

First Name_____ MI____ Last Name_____
Home Address_____ City_____ State_____ Zip_____
Email_____ Driver's Lic_____ State_____ Age_____
Home Phone(_____)_____Mobile Phone(_____)_____Gender_____
SSN#_____ Date of Birth _____Marital Status _____
Employer/School Info_____ Mobile Phone Carrier_____

RESPONSIBLE PARTY INFORMATION (If different from client)

First Name_____ MI_____ Last Name_____
Home Address_____City_____State_____Zip_____
Email_____ Driver's Lic_____State Age_____
Home Phone (_____)_____Alt Phone(_____)_____Gender_____
SSN#_____ Date of Birth_____ Marital Status_____
Employer/School Info_____

INSURANCE INFORMATION

Insurance Company_____ Insurance Co Phone_____
Claims Address_____City_____State_____Zip_____
Group Policy#_____ Subscriber ID#_____
Referring Physician_____ Phone #_____
Authorization #_____Co-payment amount_____

SECONDARY INSURANCE INFORMATION (If applicable)

Insurance Company_____ Insurance Co Phone_____
Claims Address_____ City_____ State_____ Zip_____
Group Policy #_____ Subscriber ID#_____
Referring Physician_____ Phone #_____
Authorization #_____Co-payment amount_____

ADDITIONAL INFORMATION

DCS/Court Involvement? Yes No Previously If yes or previously provide date: _____
Email Address_____
May we leave a message? Home _____ Email_____ Work_____ Cell_____ Other _____ No_____
Would you like text message appointment reminders? Yes No/ On what number? _____