CHURCHILL COUNSELING SERVICES
Registration Information

Date_____ Client Case/Social Security #_____

Client Name_____ Birth Date_____ Age_____
Sex M___ F___ Marital Status _____ Ethnicity (optional)_____
Address_____
City_____ State_____ Zip _____ County_____
Phone: Home_____OK to call?_____ Other_____OK to call?_____
Occupation_____ Employer_____
Guardian/Conservator/Personal Rep (Name & Relationship)_____
Address_____ Phone_____

Name of Person Responsible for Payment _____
Address_____
Phone: Home_____ Other_____

Who may we contact in case of an emergency?_____
Relationship to client_____ Phone: Home_____ Other_____
Address_____

Referred by_____
May we contact the person who referred you to CCS? Yes_____ No_____ Mailed_____

PRIMARY INSURANCE

Name of Insured_____ Birth Date_____
Address_____
Phone: Home_____ Work_____
SocSec #_____ Relationship to client_____
Insured's Employer_____
Phone_____
Employer Address_____City_____State_____Zip_____
Insurance Company Name_____ Phone_____
Address_____City_____State_____Zip_____
Policy/Certif/ID#_____ Group #_____

SECONDARY INSURANCE

Name of Insured_____ Birth Date_____
Address_____
Phone: Home_____ Work_____
SocSec #_____ Relationship to Client_____
Insured's Employer_____ Phone_____
Employer Address_____City_____State_____Zip_____
Insurance Company Name_____ Phone_____
Address_____City_____State_____Zip_____
Policy/Certif/ID#_____ Group #_____

For Office Use Only: CoPay/Self Pay_____