

**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: \_\_\_\_\_ OK to call? \_\_\_\_\_ Email Address: \_\_\_\_\_

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 \_\_\_\_\_