

Tiffany Griffiths, Psy.D. & Associates, Inc.

**CLIENT REGISTRATION FORM**

Intake Date \_\_\_\_\_ Office \_\_\_\_\_

Name \_\_\_\_\_ Marital Status \_\_\_\_\_

If Child, Parent's Names \_\_\_\_\_ Parent's Marital Status \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SSN \_\_\_\_\_ Home Phone \_\_\_\_\_

Email Address \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Complete Address \_\_\_\_\_

Employer \_\_\_\_\_

Other number(s) where you can be reached \_\_\_\_\_

Do we have permission to reach you at the above numbers? YES NO

Please specify if there are any requests with regards to contacting you:

\_\_\_\_\_

Referred by \_\_\_\_\_ Relationship \_\_\_\_\_

**MEDICAL INFORMATION**

Personal Physician and Address \_\_\_\_\_

Date of Last Physical \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Current Medications \_\_\_\_\_

Medication Allergies and Reactions \_\_\_\_\_

Major/Chronic Illnesses \_\_\_\_\_ Previous Psychotherapy? Yes/No

If Yes, Dates and Therapist \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Company \_\_\_\_\_ Name of Insured \_\_\_\_\_

Date of Birth of Insured \_\_\_\_\_ Insurance Company's Phone \_\_\_\_\_

Insurance Company's Billing Address \_\_\_\_\_

Insurance Group Number \_\_\_\_\_ ID \_\_\_\_\_

