THRIVE
COUNSELING & CONSULTING, PLLC

REGISTRATION FORM

Please make sure our office staff copies your insurance/ID Card

SECTION I: Patient/Client Information Date:_____

Name:_____ Nickname:_____ Age:_____Gender: _____ Race:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell Phone: _____ Work Phone: _____ Other Phone: _____

The best number to contact me (or parent) is: □ Home Phone □ Work Phone □ Cell Phone

Can we contact you by email? *Email address*: _____

Will you accept texts for appt reminders? *Y / N* Date of birth: ____ / ____ / ____ Social Security #: _____

Check appropriate box: □ Minor □ Single □ Married □ Widowed □ Separated □ Divorced

If student, name of school: _____ City/State: _____ FT / PT

Emergency Contact: _____ Relationship: _____Phone: _____

Best weekdays and times for you to schedule appointments: _____

Do you have other family members who are seen here? _____

SECTION II: Responsible Party – Spouse or Parent/Guardian info, If client is a child

Relationship to Patient: □ Self □ Spouse □ Parent □ Other

Name (printed): _____ SSN: _____

Address (If different than above): _____

City: _____ State: _____ Zip: _____ Phone: _____

Employer: _____ Work Phone: _____

SECTION III: Insurance Information

Please circle one: Aetna • BCBS • Cash • Cigna • Tricare Prime • Tricare Prime Retired
Tricare Standard • Tricare Standard Retired • Other: _____

Name of Insured (Sponsor): _____ DOB: _____

Relationship to Patient: _____

Sponsor SSN: _____ Name of Employer: _____ Work Phone: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Insurance Company: _____ Group #: _____ ID #: _____

By providing this information, you are authorizing us to bill your insurance(s) for services provided to you for your family members.

DO YOU HAVE ANY ADDITIONAL INSURANCE? □ YES □ NO *IF YES, COMPLETE THE FOLLOWING:*

Insurance Company: _____ Group #: _____ ID #:_____

YOU MUST inform us immediately if there are any insurance changes, or you may be responsible for payment.

SECTION IV: Additional Family Members

If you'd like to make an appointment for a family member, please list them below:

Name	Age	Insurance Type
_____	_____	_____
_____	_____	_____