Client Registration Form -

Steven P. Hymen, PhD, PS

TODAY'S DATE:_____ **How did you hear about me/Who referred you to me?**_____

NAME:_____ **Sex: M ( ) F ( ) DOB:**_____

MAILING ADDRESS:_____ **CITY:**_____ **STATE:**_____

ZIP CODE:_____ **Do I have your permission to send mail to your home address? Yes No**

HOME PHONE:_____ **May I call this number? Yes No Leave a message? Yes No**

MOBILE/MESSAGE PHONE:_____ **May I call this number? Yes No Leave a message? Yes No**

WORK PHONE:_____ **May I call this number? Yes No Leave a message? Yes No**

E-MAIL ADDRESS : _____ **May I e-mail you? Yes No**

EMPLOYER:_____ **OCCUPATION:**_____

NAME OF SPOUSE/PARTNER (if applicable): _____

EMERGENCY CONTACT INFORMATION
Person to contact in the event of an emergency:

NAME:_____ **RELATIONSHIP TO CLIENT:**_____

HOME PHONE:_____ **WORK PHONE:** _____

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INSURANCE INFORMATION (Complete in full and provide a photocopy of your card)

PRIMARY INSURANCE:_____ **PHONE:**_____

ADDRESS:_____ **ZIP:**_____

SUBSCRIBER'S NAME:_____ **INS. ID#:**_____ **SUB'S DOB:**_____

GROUP/EMPLOYER NAME:_____ **GROUP #:**_____

CLAIM #(if applicable):_____ **AUTHORIZATION # (if applicable):**_____

Does a separate company manage these mental health benefits? If so, please include:

NAME OF MANAGED CARE COMPANY:_____ **PHONE:**_____

ADDRESS:_____ **ZIP:**_____

SECONDARY INSURANCE:_____ **PHONE:**_____

ADDRESS:_____ **ZIP:**_____

SUBSCRIBER'S NAME:_____ **INS. ID#:**_____ **SUB'S DOB:**_____

GROUP/EMPLOYER NAME:_____ **GROUP #:**_____

CLAIM #(if applicable):_____ **AUTHORIZATION # (if applicable):**_____

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PRIMARY CARE DR:_____ **PHONE:**_____ **FAX:**_____

ADDRESS:_____ **ZIP:**_____

PHYSICIAN/SPECIALIST :_____ **PHONE:**_____ **FAX:**_____

ADDRESS:_____ **ZIP:**_____

PSYCHIATRIST (if applicable):_____ **PHONE:**_____ **FAX:**_____

ADDRESS:_____ **ZIP:**_____