Juniper Tree Counseling Services
Toni L. Wood M.S., L.P.C.
CLIENT REGISTRATION SHEET

Patient Name: _____ **Home Phone: (_____)** _____
(Last) (First) (M.I.)

Address: _____ **Work Phone: (_____)**_____
(Street or P.O. Box) (Apt or Rt. #) (If minor, list parent's #)

_____ **Cell Phone: (_____)** _____
(City) (State) (ZIP)

Sex: ____M _____F **DOB:** ____/_____/_____ **SS#:**____/_____/_____ **Referred by:** _____

Employer: _____ **Address:** _____
(if patient is minor, list parent's)

Spouse's Name: _____ **Employer:** _____ **Phone: (_____)**_____

School Name: (If Student) _____ **Grade Level:** _____

Who is responsible for payment of services (if different from above)?

Name: _____ **Relation to Client:** _____
(Last) (First) (M.I.)

Address: _____
(Street or P.O. Box) (Apt or Rt.) (City) (State) (ZIP)

Work Phone: (_____)_____ **Home Phone: (_____)**_____ **SS#:** _____/_____/_____

_____
(Street or P.O. Box) (Apt or Rt. #) (City) (State) (ZIP)

Primary Insurance: _____ **Phone: (_____)**_____

Insurance Company's Address: _____

Insured's Name: _____ **DOB:** _____/_____/_____ **Sex:** _____M _____F

Insured's ID #: _____ **Group #:** _____

Relationship to Client: _____ **Employer Plan:** _____Yes _____No

Employer: _____

NOTIFY IN EMERGENCY: _____ Relation: _____
Home Phone: _____
Work Phone: _____

I authorize the release of Private Healthcare Information required, in the course of my services with Toni L. Wood M.S., L.P.C., to process third-party claims for benefits.

_____ _____
Signature of Client or Responsible Party Date

I authorize claim's benefits for above client to be paid directly to Toni L. Wood M.S., L.P.C.

_____ _____
Signature of Client or Responsible Party Date