Associates of Behavioral Health Northwest REGISTRATION FORM

Name:		Date:	
(First) (M.I.) (Last)			
CURRENT ADDR			
Address Line 1: _			
Address Line 2:			
City:	State: _	Zip code:	
DATE OF BIRTH	:		
//			
AGE:			
GENDER:			
□ M □ F	= 🚨 Oth	ner	
TELEPHONE CO	NTACT INFOR	MATION Please indicate the numbe	r at which you prefer to be
		can be left at that number.	, ,
Home:	_	OK to leave message? YES	NO
Cell:		OK to leave message? YES	
Work:		OK to leave message? YES	
Other:		OK to leave message? YES	
INSURANCE INF	ORMATION		
Insurance Provide	er: ID Number A	ND Group Number	
		Zip code:	
		nt): Relationship of insured to cli	ent [.]
•		ity). I tolationomp of inloared to on	
			
Employer Address	J		
	•••	☐ Single ☐ Divorced	
DEMOGRAPHIC	5 Marital Status	- Single - Divorced	
# Years			
☐ Married # Years	—— Voore		
□ Living as Married # `□ Separated # Years			
☐ Widowed # Years		tner Name:	

If therapi
is unable to reach you, is it OK to contact your spouse/partner? YES No_
Employment School Status
Are you currently employed? YES NO
Are you currently enrolled in school? YES NO If yes, please specify:
□ Full-time □ Part-time □ Retired □ Seasonal □ Unemployed □ Other:
If yes, please specify:
□ Full-time □ Part-time □ Non-credit courses □ Trade/vocational □ Other: :
Employer Name: School/University Name:
EMERGENCY CONTACTS Please list at least ONE person that can be contacted by your
therapist in the event of an emergency.
Name:
Ok to leave message? Address:
YES NO Phone:
Relationship to you:
Name:
Address:
Phone:
PRIMARY CARE PHYSICIAN
Current Physician Name:
Address:
Phone:
Fax Number
Date of last physical exam:
REFERENT INFORMATION By whom were you referred? Phone:
<u></u>
Consent for Release of Information By signing below, I am authorizing my Protecte
Health Information (PHI) to be used and disclosed to my insurance company or other
private payors for billing purposes.
Client Signature Date Witness/Therenist Date
Client Signature Date Witness/Therapist Dat