

NEW CLIENT REGISTRATION FORM

Howard L. Leonard, Ph.D.

818 -12th Avenue

Seattle, WA 98122

Date _____

Name _____ Age _____ Sex _____ Date of Birth _____

Address _____ City _____ Zip _____

Email: _____ May I contact you at this email address? _____

Home Phone _____ May I call you at this #? _____

Cell Phone _____ May I call you at this #? _____

Work Phone _____ May I call you at this #? _____

Employer _____ Occupation _____

Work Address _____ City _____ Zip _____

Who referred you to Dr.Leonard? _____

Name of Physician _____ Dr.'s Phone _____

Billing, Insurance & Health Information:

Person Responsible for Bill _____ Relationship to You _____

Contact Information if other than self

1. Primary Insurance _____ Name of Insured _____

Subscriber # _____ Subscriber DOB _____ Group # _____

Billing Address _____ Billing Phone _____

If this is a Managed Care Plan, did you obtain Pre-Authorization? _____

Phone _____

Managed Care Company _____

Address _____

2. Secondary Insurance _____ Name of Insured _____

Subscriber # _____ Subscriber DOB _____ Group # _____

Billing Address _____ Billing Phone _____

If this is a Managed Care Plan, did you obtain Pre-Authorization? _____ Phone _____

Managed Care Company _____ Address _____

Personal and Household Information:

Describe any previous psychotherapy including approximate dates

Relationship Status _____ How long Have you been in this relationship _____

Spouse/Partner's Name _____ Name & Ages of Dependents:

Who lives in your household & what is your relationship to them?

Educational Background

Religious/Spiritual Activities: Present _____ Past _____

Sexual Orientation Heterosexual _____ Bisexual _____ Gay/Lesbian _____ Other _____
Uncertain _____

Have you ever been Abused Physically Yes _____ No _____ Uncertain _____

Emotionally Yes _____ No _____ Uncertain _____

Sexually Yes _____ No _____ Uncertain _____

Describe your use of: Prescription Medications _____

Other Legal / Street Drugs _____

Alcohol _____

Tobacco _____

Caffeine _____

Emergency Contact:

By providing the below information, I am allowing Dr. Howard Leonard or his staff to contact this person should there be an emergent reason to do so. No one will contact this person unless there is an emergency:

Name _____ Relationship to You _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Other Phone _____

Thank You!

Revised 10/2010