New Client Registration

THOMAS LAND,PsyD
818 12TH AVENUE
SEATTLE, WA 98122

Name: ______________________ Age: __________ Sex: ______

Address: ______________________ Social Sec #: __________

______________________ Date of Birth: __________
City State Zip

Home Phone: __________ May I call you at this number Y N Leave a message at this number Y N

Person Responsible For Bill: __________ Relationship: __________

Address __________ Phone: __________

Email (optional) __________

Employer Information

Employer: ______________________

Address: ______________________

Work Phone: __________ May I call you at this number Y N Leave a message at this number Y N

Insurance Information

Name of Insured: __________ SS # __________ Date of Birth __________

Primary Insurance Company: ______________________

Address: ______________________

Subscriber or ID # __________ Group # __________

Name of Insured: __________ SS # __________ Date of Birth __________

Secondary Insurance Company: ______________________

Address: ______________________

Subscriber or ID # __________ Group # __________

- DX: __________ [FOR OFFICE USE ONLY]

- continued -

Medical & Referral Information

Name of Physician: ______________________ Date of Last Physical ____________

Previous Mental Health Treatment:

Dates	Provider	Inpatient/Outpatient

Current Medications:

Name	Dosage	Frequency

Medical conditions for which you are currently being treated?

Condition	Person (s) providing treatment

By whom were You referred to our office?: ______________________ Relationship ____________

Household Information

Names	Gender	Age	Relationship to you

Emergency Contact

In Emergency, Contact: ______________________ Relationship: ____________

Address: ______________________

Home Phone: ______________________ Work Phone: ____________

Legal Next of Kin: ______________________ Relationship: ____________

Address: ______________________

Home Phone: ______________________ Work Phone: ____________