Client Registration

Streamline
HEALTH CARE SOLUTIONS

INSTRUCTIONS - Please provide as much information on this form as possible.

First Name | Middle Initial | Last Name

Home Phone Number

Address 1

Work Phone Number

Address 2

Mobile Phone Number

City | State | Zip Code

Date of Birth

Emergency Contact

Emergency Contact Phone #

Primary Care Physician Contact

PCP Contact Phone #

Sex: ☐ Male ☐ Female

Relationship Status: ☐ Single ☐ Married ☐ Other

Employment Status: ☐ Employed ☐ F/T Student ☐ P/T Student

How did you hear of us?

During the past year have you been seen elsewhere for mental health services?

☐ Yes (Please complete this section)

☐ No (Skip this section)

Clinic/Therapist Name

Clinic/Therapist Location

Clinic/Therapist Phone #

Type of service?

☐ Individual Therapy

☐ Family Therapy

☐ Group Therapy

☐ Medication Mgmt.

Insurance Information: ☐ Yes (Please complete this section) ☐ No (Skip this section)

Primary Insurance Company Name | Phone Number (back of card) | Policy Number

Primary Insurance Subscriber's Name | Date of Birth | Co-pay

Client's relationship to insured?

☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance Company Name | Phone Number (back of card) | Policy Number

Secondary Insurance Subscriber's Name | Date of Birth | Co-pay

Client's relationship to insured?

☐ Self ☐ Spouse ☐ Child ☐ Other

By signing below, I attest that the information provided above is true and accurate.

Printed Client Name (or parent/legal guardian) | Client Signature (or parent/legal guardian) | Today's Date

Office Use:

Lynette Ingram Cassel, ATR, LMHC

Clinician/Practice Name

☐ Insurance ☐ Out-of-pocket

Clear Form

Print Form