Hope Counseling Center, LLC
Betty Lacine, MS, LPCC, RPT
507-250-6234

ADULT CLIENT REGISTRATION FORM

Date:_____ Client Name:_____

Birth Date: _____ Male_____ Female_____

Street Address:_____

City:_____ State: _____ Zip: _____

Telephone #: (H) _____(W)_____

Employer:_____ Occupation: _____

Ethnicity: _____

How did you hear about Hope Counseling? _____

Medication: _____

Who is your prescribing physician? _____

Physician affiliation:_____

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Emergency Contact: Name: _____ phone #_____

Relationship: _____

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CHILDREN:
Please list the following information for each child beginning with the oldest:

Last Name First Name Birth Date School Grade Lives with you? (Y/N)

_____

_____

_____

_____

INSURANCE INFORMATION: Please provide a copy of your insurance card.

Primary Insurance: _____

Plan number: _____ Group number: _____

Name of policy holder:_____

Policy holders date of birth: _____ SS#:_____

Secondary Insurance: _____

Plan number: _____ Group number: _____

Name of policy holder:_____

Policy holders date of birth: _____ SS#:_____