Betty Lacine, MS, LPCC, RPT
507-250-6234

CHILD CLIENT REGISTRATION FORM

Date:_____ Client Name:_____

Birth Date: _____ Male_____ Female_____

Street Address:_____

City:_____ State: _____ Zip: _____

Ethnicity: _____ County: _____

Telephone #: _____

School: _____ Grade Level:_____

How did you hear about Hope Counseling? _____

Medication: _____

Who is your prescribing physician? _____

Physician affiliation:_____

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Parental Information:

Mother's Name:_____

Mother's Home address: _____

Telephone #: (H) _____(W)_____

Date of Birth: _____

Employer:_____ Occupation: _____

Parental Information: (continued)

Father's Name: _____

Father's Home Address: _____

Telephone # (H): _____ (W): _____

SS#: _____ Date of Birth: _____

Employer:_____ Occupation: _____

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SIBLINGS: 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#:_____