THERAPIST: _____

The Therapy Place of La Crosse, LLC

Client Registration

Client:

Name (last):_____(first):_____MI_____

Street Address:_____

City, State, Zip:_____

Phone number:_____ May we leave a message? Y/N

Email Address:_____

Age:_____ Gender:_____ Date of Birth:_____ SS #:_____

Employer:_____

Emergency Contact:

Name_____Relationship:_____

Phone Number_____

Insurance Information:

Name of Health Plan:_____

Primary Insurance Card Holder:_____

Primary Insurance Card Holder's Date of Birth:_____

Primary Insurance Card Holder's SS#:(allows us to verify the insurance):_____

Primary Insurance Card Holder's Phone Number:_____

Signature_____Date_____