SCRIPPS RANCH CENTER FOR BEHAVIORAL HEALTH
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CLIENT REGISTRATION: ADULT FORM

1. Personal Information **Today's Date:**_____

Full Name:_____ Date of Birth:_____ Age:_____

Address:_____

City:_____ State_____ Zip_____

Marital Status:_____ Home Phone: (____)_____ Work: (____)_____

Home Phone: (____)_____Work:(____)_____ Cell/Mobile:(____)_____

Ethnicity:_____ Religious Affiliation:_____

Emergency Contact Information

Name:_____ Relationship:_____

Address:_____

Home Phone: (____)_____Work:(____)_____ Cell/Mobile:(____)_____

2. Responsibility Party Information

Name of Responsible Party_____

Address (if different than client's)_____

Relationship:_____ Birth Date:_____ SS#_____

Place of Employment:_____ Length of Employment:_____

Home Phone: (____)_____Work Phone: (____)_____

Cell Phone: (____)_____ Child's Legal Guardians:_____

Name of Primary Health Insurance:_____

Group Number:_____ Policy/Subscriber Number:_____

Address of Primary Insurance:_____ Phone Number:_____

Please provide a copy of insurance card

PAYMENT AUTHORIZATION

I understand that it is my responsibility to pay the fee established for professional services rendered to the above client. I hereby authorize insurance payment directly to Kenneth Heying, Ph.D. or Brad Miller, Psy.D. (circle one). Please note that **24 hours** advance notice is required to cancel an appointment in order to avoid late charges.

Signature of Responsible Party:_____ Date:_____