

\_\_\_\_\_ Clinician

\_\_\_\_\_ Record #

**CLIENT REGISTRATION – PEACE OF MIND, INC.**

CLIENT'S LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INITIAL \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_ SEX \_\_\_\_\_ EMAIL ADDRESS \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK/CELL PHONE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

CLIENT'S SOCIAL SECURITY NUMBER \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

**GUARANTOR INFORMATION** (Please complete if client is a minor)

MOTHER'S NAME: \_\_\_\_\_ SSN \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ SSN \_\_\_\_\_

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1. TRICARE: PRIME: \_\_\_\_\_ EFF.DATE: \_\_\_\_\_ EXTRA: \_\_\_\_\_

SPONSOR NAME: \_\_\_\_\_ SPONSOR RANK: \_\_\_\_\_

SPONSOR SSN#: \_\_\_\_\_ SPONSOR DOB: \_\_\_\_\_

TRICARE AUTHORIZATION #: \_\_\_\_\_

2. INSURANCE CO.: \_\_\_\_\_ PHONE#: \_\_\_\_\_

SUBSCRIBER NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

POLICY ID#: \_\_\_\_\_ GROUP #: \_\_\_\_\_

SSN#: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

3. MEDICAID \_\_\_\_\_ RECIPIENT ID#: \_\_\_\_\_

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**(Please complete if client is a minor)**

NAME OF ADULT CHILD LIVES WITH. \_\_\_\_\_

WHO HAS LEGAL CUSTODY OF THE CHILD? \_\_\_\_\_

NAMES OF OTHER PEOPLE LIVING IN THE HOME \_\_\_\_\_

SCHOOL GRADE \_\_\_\_\_ NAME OF SCHOOL \_\_\_\_\_

TEACHER/COUNSELOR NAMES \_\_\_\_\_ PHONE # \_\_\_\_\_

**\*PLEASE TURN OVER AND CONTINUE ON BACK SIDE\***

\_\_\_\_\_ Clinician

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FAMILY PHYSICIAN \_\_\_\_\_

ALLERGIES \_\_\_\_\_

MEDICAL PROBLEMS AND CURRENT MEDICATIONS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ISSUES BRINGING YOU TO COUNSELING \_\_\_\_\_

WHAT YOU HOPE TO CHANGE \_\_\_\_\_

As a courtesy, we generally call to remind our clients of scheduled appointments. This may cause confidentiality concerns for you and because of this, we would like to give you the opportunity to either request or decline this courtesy call. Please do so by initialing your preference:

\_\_\_\_\_ PLEASE CALL      \_\_\_\_\_ PLEASE LEAVE MESSAGE      \_\_\_\_\_ DO NOT CALL

WHO REFERRED YOU TO US? \_\_\_\_\_

MAY WE CONTACT THEM TO EXPRESS OUR GRATITUDE? \_\_\_\_\_

Providing information on race/ethnicity is voluntary and will be held confidential. The \_\_\_\_\_ strives to provide services to all families in a culturally sensitive manner. In order to assist us in meeting the needs of our culturally diverse population, we ask that you complete the following section:

PLEASE SPECIFY THE CLIENT'S CULTURAL/ETHNIC GROUP:

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> White       | <input type="checkbox"/> Black                               |
| <input type="checkbox"/> Hispanic    | <input type="checkbox"/> Native American                     |
| <input type="checkbox"/> Asian       | <input type="checkbox"/> Biracial (biological mother): _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> (biological father): _____          |

NAME OF PERSON WE MAY CONTACT IN CASE OF EMERGENCY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

**I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION OBTAINED DURING EVALUATIONS OR TREATMENT OF THIS CLIENT TO THE INSURANCE COMPANY INDICATED ABOVE WHICH IS NECESSARY TO EXPEDITE AND SUPPORT ANY INSURANCE CLAIMS ON THIS ACCOUNT. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES, REGARDLESS OF INSURANCE COVERAGE. I AUTHORIZE THE PAYMENT OF BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THIS PROVIDER. MEDICARE REGULATIONS MAY APPLY.**

\_\_\_\_\_  
Client/Legally Responsible Person's Signature

\_\_\_\_\_  
Date