DATE:

PATIENT REGISTRATION

DX:

PROVIDER: Thomas Stein

PATIENT DETAIL:

***Legal Name:** **Last** **First** **MI**		☐Male ☐Female	☐Married ☐Single	Referred by:
***Street Address** **Apt #**		**City**		**Zip Code**
Phone#:		***Birth Date:**		
EMAIL :				
***Employment/School:**				

RESPONSIBLE PARTY: *Card holder, parent or guardian if patient is minor*

Legal Name: Last First MI		Relationship: ☐Parent or Guardian ☐ Other_____ ☐Responsible Party_____	
Street Address Apt#		Insured	
City & Zip Code		**Birth Date:**	☐Male ☐Female
Employment:			

FOR EAP OR SECONDARY INSURANCE

EAP/Insurance ID #:

Number of Sessions Authorized:

Insurance Company:

Authorization #:

Authorization to release information: I agree that if insurance denies or reduces the level of service received I will be liable for the limiting rate established for treatment I received as submitted to insurance. I hereby authorize Thomas Stein to furnish the insurance company or others authorized by law with full information regarding treatment rendered when so required.

PATIENT'S SIGNATURE_____