Tiffany Griffiths, Psy.D. & Associates, Inc.

CLIENT REGISTRATION FORM

Intake Date____ Office ___________________________

Name ____ Marital Status______________________

If Child, Parent's Names_____________ ____________________ Parent's Marital Status____ __________

Date of Birth __________ Age _________ SSN _______________ Home Phone _____________________

Email Address____ Mobile Phone_____________________

Complete Address____

Employer ____

Other number(s) where you can be reached ____

Do we have permission to reach you at the above numbers? YES NO

Please specify if there are any requests with regards to contacting you:

____

Referred by ____________________________________ Relationship ______________________________________

MEDICAL INFORMATION

Personal Physician and Address ____ ______________________

Date of Last Physical _________________ Height______________________Weight __________________________

Current Medications ____

Medication Allergies and Reactions____

Major/Chronic Illnesses ______________________ ______________________ Previous Psychotherapy? Yes/No

If Yes, Dates and Therapist ____

INSURANCE INFORMATION

Primary Insurance Company ____________________________ Name of Insured__________________________

Date of Birth of Insured_________________ Insurance Company's Phone _______________

Insurance Company's Billing Address _______________ ____

Insurance Group Number __________________________ ID ____

Primary Insurance Company ___________________________ Name of Insured_________________________

Date of Birth of Insured________________ Insurance Company's Phone ______________

Insurance Company's Billing Address ____

Insurance Group Number ________________________ ID ____

SIGNATURE ON FILE: I authorize use of this form on all of my insurance submissions. I authorize Tiffany Griffiths, Psy.D. & Associates, Inc. to bill my insurance for all services rendered. I authorize insurance payments to be made directly to Tiffany Griffiths, Psy.D. & Associates, Inc. I understand that I am ultimately responsible for any outstanding balance not covered by my insurance.

_____________________________________ ______________________________ ____________________

Print Name Here **Signature** **Date**

Please list any special insurance billing information or instructions

____

Emergency Contact _________________________________Relationship ______________________________

Address and Phone ____

Please do not complete below this line

FOR OFFICE USE ONLY

Preliminary Diagnosis and Code:

Assigned to:

Appointment Date/Time:

Notes:

10/17