

REGISTRATION FORM FOR TEENS (AGES 13-17)

TODAY'S DATE: \_\_\_\_\_ TEEN'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ SEX: M / F

First M.I. Last

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

Street City State Zip

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ TEEN CELL PHONE: (\_\_\_\_) \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ PREVIOUS COUNSELING WITH: \_\_\_\_\_

REGULAR MEDICATIONS: \_\_\_\_\_ ALLERGIES: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ SIGNIFICANT HEALTH ISSUES: \_\_\_\_\_

NAME OF PARENT OR GUARDIAN SEEKING TREATMENT FOR CHILD: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

Father's address if different from above: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE : (\_\_\_\_) \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ Please circle best number to reach during the day: Home Cell Work

MOTHER'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

Mother's address if different from above: \_\_\_\_\_

HOME PHONE: (\_\_\_\_) \_\_\_\_\_ CELL PHONE: (\_\_\_\_) \_\_\_\_\_

WORK PHONE: (\_\_\_\_) \_\_\_\_\_ Please circle best number to reach during the day: Home Cell Work

PRIMARY INSURANCE CARRIER: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

SECONDARY INSURANCE CARRIER: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Employer: \_\_\_\_\_

Policy Holder's Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

FAMILY MEMBERS:

Name	Relationship to Child	Age	Living with Child?
> _____	> _____	> _____	Yes/No
> _____	> _____	> _____	Yes/No
> _____	> _____	> _____	Yes/No
> _____	> _____	> _____	Yes/No
> _____	> _____	> _____	Yes/No
> _____	> _____	> _____	Yes/No
> _____	> _____	> _____	Yes/No
> _____	> _____	> _____	Yes/No

BILL ANY OUTSTANDING BALANCE TO: Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

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

Street City State Zip

(Please note that outstanding balances will not be billed to a non-custodial parent without his/her express written consent.)

Signature of Person Completing Form: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

FOR OFFICE USE ONLY: DSM CODE: \_\_\_\_\_ FEE SCHEDULE: \_\_\_\_\_