

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: _____