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 _____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: