Hope Counseling
CENTER OF SAVANNAH

Patient Registration

Patient Name: _____Date of Birth:_____

SSN: _____ Gender: ____Male ____Female

Address: _____

City: State: Zip: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email:_____

Preferred form of communication:_____

Is patient a minor/ dependent?_____

Responsible Party Name:_____Relationship to Patient_____

Primary Insurance: _____ID#_____

Group #:_____ Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Secondary Insurance, if applicable: _____ ID#_____

Group #:_____ Policy Holder: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Relationship to Patient: _____

Emergency Contact:

Name: _____Relationship to Patient:_____

Home Phone: _____ Cell Phone:_____

Work Phone:_____

Referring Physician:_____

Responsibility Party Signature: _____