Life Perspectives Counseling Services, LLC

REGISTRATION FORM

First Name	Last Name	Today's Date:
Full Address:	City:	State: ZIP:
Date of Birth:	Age	Gender: □M □F	Marital Status:
Home #	Mobile #	Work #
Email:	
Which number would you prefer to receive messages (if any)?	
Ethnicity: □AA □Caribbean □Latino □White □Asian □Other (describe):	
Occupation:	Employed by:
Referred by:	Reason Referred:

Emergency Contact

Name:	Telephone (cell/home/work):
Relationship:	

Insurance Information

Name of Insurance Company:	Name of Insured:
Policy Number:	Insured's DOB:
Group Number:	Relationship to Insured:
Type Of Policy: HMO POS PPO	Contact number(s) for insurance company:

If Client is a Minor:

Parent/Guardian Name:	Relationship to Minor:
Address if different from above:	
Guardian Contact information:	
Home	Work:	Mobile:
School Name	Grade	Special Ed Yes___ No___
Previous Counseling: □YES □NO When: _____ Where: _____ Why:_____	