Living In Authority Counseling Services, PLLC
PH# 210.816.1896 fax 210.881.9022

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name/ First	Middle	Last		
Address	City	State	Zip	
Home Phone ( )	Cell Phone ( )	E-mail:		
SSN	Date of Birth	Age	Gender M F	Marital Status:

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name/ First	Middle	Last	
Address	City	State	Zip
Date of Birth	SSN	Employer	
Home Phone ( )	Work Phone ( )	Cell Phone ( )	

EMERGENCY CONTACT

Name	Relationship	
Home Phone ( )	Work Phone ( )	Cell Phone ( )

INSURANCE INFORMATION

Primary Insurance Company	Insurance Phone # ( )		
Claims Address	City	State	Zip Code
Primary Cardholder's Name	ID #	SSN	Group #
Insured's Employer	Home Phone ( )	Work Phone ( )	Date of Birth

Secondary Insurance Company	Insurance Phone # ( )		
Claims Address	City	State	Zip Code
Primary Cardholder's Name	ID #	SSN	Group #
Insured's Employer	Home Phone ( )	Work Phone ( )	Date of Birth