

# Sally Markley ATR, LPC

2561-2 E. Ft. Lowell Rd. Tucson, AZ 85716 (520) 903-8877

## Patient Registration Information: Child/Family Services

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_ District: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Mothers Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Fathers Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Siblings Name(s)/DOB/Age \_\_\_\_\_

Marital/Custody Status of Parents: \_\_\_\_\_

\*Please additional form for separate households

## Payment/Insurance Information:

EAP: Name of EAP: \_\_\_\_\_ Name of Employer: \_\_\_\_\_

Pre- Authorization# \_\_\_\_\_ Phone # \_\_\_\_\_ Fax# \_\_\_\_\_

Authorized Number of Sessions: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Plan: \_\_\_\_\_

Member # \_\_\_\_\_ Group# \_\_\_\_\_

Primary Policy Holder Name/DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to client: \_\_\_\_\_ Employer Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Authorization # \_\_\_\_\_ Co-Pay: \_\_\_\_\_ Deductible: \_\_\_\_\_ Calendar Year Date: \_\_\_\_\_

Amount of Family Sessions Covered: \_\_\_\_\_ Amount of Individual Sessions Covered: \_\_\_\_\_

Other insurance Information: \_\_\_\_\_

## Notice Incase of emergency:

Name: \_\_\_\_\_ Relation \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Allergies or Medical Condition the may affect treatment: \_\_\_\_\_

Last medical Appointment: Any Concerns: \_\_\_\_\_

Medications and Dosages: \_\_\_\_\_

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## Family Household(s):

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family/Household Member Name	Relation to Client	DOB	Age

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Family/Household Member Name	Relation to Client	DOB	Age

## Involved Extended Family Member Not in the home:

Family/Household Member Name	Relation to Client	DOB	Age