Scott M. Turner LMSW
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Phone: 810-216-5610
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REGISTRATION FORM

Date _____

Client's First Name_____ MI_____ Last Name_____
Client's Social Security #_____ Birth date _____ Age_____
Gender __Female __Male Race/Ethnicity_____ Marital Status _____
Telephone (#1)_____ (#2)_____ (#3)_____
Address_____ City_____ State_____ Zip_____
Email _____
Name of Spouse/Guardian_____ Phone_____
Address_____ City_____ State_____ Zip_____
Person Responsible for Payment_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:
Name (1) _____ Relationship_____ Phone 1_____Phone 2 _____
Name (2) _____ Relationship_____ Phone 1_____Phone 2 _____

Physician/Medication Information

Physician_____ Phone_____
Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____
Address_____ City_____ State_____ Zip_____

Other Physicians_____ Phone_____

Current Medications_____
Allergies_____

Employment or School Information

Place_____ Phone_____ Hrs_____
Place_____ Phone_____ Hrs_____

Insurance Information

Primary Insurance_____
Phone_____
Contract/ID#_____
Group/Acct#_____
Subscriber_____
Subscriber Date of Birth _____
Client's relationship to Subscriber:
__Self __Spouse __Child __Other_____

Secondary Insurance_____
Phone_____
Contract/ID#_____
Group/Acct#_____
Subscriber_____
Subscriber Date of Birth_____
Client's relationship to Subscriber:
__Self __Spouse __Child __Other_____

Referral Source

How did you hear of our clinic (or from whom)?_____
Phone_____ Relationship to referral source _____