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CLIENT REGISTRATION FORM

Name: ____

Address |City | State | Zip: ____

Email Address: ____ Can I email you? ____ Yes ___ No

Preferred Telephone: __________________________________ Can I leave a voicemail? ___Yes ___No

Can I text this number? ___Yes ___No

Please note, I cannot guarantee confidentiality within texts or electronic communication. By selecting these methods, you acknowledge this risk and consent to its use.

Birthdate: ____

Occupation/Employer: ____

Insurance Company: __________________ Member ID#__________________ Group ID#_____________________

If insurance is not under your name, name of insured: ______________________ DOB of insured: _______________

Referred by: ____

Please list any medications (if applicable): ____

Prescribing Physician Name: ____

Phone Number: ____

Emergency Contact Name/Relationship: _____________________________ Phone Number: ___________________