SARAH L. RATTRAY, PH.D.
PSYCHOLOGIST

Today's Date: ___________

# CLIENT REGISTRATION FORM:

Please fill out all sections on this form.
Be sure to completely fill out the second block if someone else is coming with you to therapy.

Check Preferred Phone #:

| Your Name M ❑ F ❑ | | Birthdate \| \|19 | Age | ❑ Home Phone # |
|---|---|---|---|---|
| Address | | | | ❑ Cell Phone # |
| City | State | Zip | | ❑ Work Phone # |
| Employer | | Occupation | | ❑ Other Phone # |
| Emergency Contact | | Relationship | | Telephone # |

| OTHER ADULT WHO IS COMING TO THERAPY: | | | | COMING ALONE ❑ |
|---|---|---|---|---|
| Other Adult's Name M ❑ F ❑ | | Birthdate \| \|19 | Age | ❑ Home Phone # |
| Address (SAME ❑) | | | | ❑ Cell Phone # |
| City | State | Zip | | ❑ Work Phone # |
| Employer | | Occupation | | ❑ Other Phone # |
| Emergency Contact | | Relationship | | Telephone # |

| PRIMARY INSURANCE: None ❑ | | |
|---|---|---|
| Policy Holder's Name | Birthdate \| \|19 | Policy Holder's ID # (SSN) |
| Employer | Occupation | Group # |
| Insurance Company | | Telephone # |
| Family Members On Plan | | Client's Relationship to Policy Holder: Self❑ Spouse❑ Child❑ Other❑ |

| SECONDARY INSURANCE: None ❑ | | |
|---|---|---|
| Policy Holder's Name | Birthdate \| \|19 | Policy Holder's ID # (SSN) |
| Employer | Occupation | Group # |
| Insurance Company | | Telephone # |
| Family Members On Plan | | Client's Relationship to Policy Holder: Self❑ Spouse❑ Child❑ Other❑ |