



# Exeter Counseling Center Registration Form

Date \_\_\_\_\_

Client's Name \_\_\_\_\_

DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone (h) \_\_\_\_\_

\_\_\_\_\_

Phone (w) \_\_\_\_\_

Phone (c) \_\_\_\_\_

Relationship status:    Single    Married    Partnered    Separated    Divorced    Widowed

Others at Home:                      Name                      Age                      Relationship

Others at Home:	Name	Age	Relationship

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last Physical \_\_\_\_\_ Relevant Medical Issues \_\_\_\_\_

Medications \_\_\_\_\_

Current concerns or symptoms prompting treatment \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### Primary Insurance

Name of company \_\_\_\_\_ Subscriber \_\_\_\_\_

Address \_\_\_\_\_ Subscriber SS# \_\_\_\_\_

Subscriber's DOB \_\_\_\_\_

Insurer's telephone # \_\_\_\_\_ Employer \_\_\_\_\_

ID/Certificate # \_\_\_\_\_ Group # \_\_\_\_\_

Please provide this information for any secondary insurance carriers on the back of this form.