



Centerville Clinic

7039 20th Ave. S., Centerville, MN 55038
Phone: 651-288-0332 Fax: 651-288-0493

White Bear Lake Clinic

4444 Centerville Rd. Suite 235, White Bear Lake, MN 55127
Phone: 651-289-3111 Fax: 651-289-3113

REGISTRATION INFORMATION

Account # For Internal Use Date:

PATIENT INFORMATION

LAST NAME FIRST NAME M.I. BIRTHDATE SPOUSE'S NAME
HOME ADDRESS CITY STATE ZIP MALE FEMALE
PATIENT'S SOCIAL SECURITY # MARITAL STATUS HOME # WORK #

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME (IF STUDENT) OCCUPATION (JOB TITLE) EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS CITY STATE ZIP

EMERGENCY INFORMATION

NEXT-OF-KIN (FOR EMERGENCY - OTHER THAN SPOUSE) RELATIONSHIP
NEXT-OF-KIN ADDRESS CITY STATE ZIP NEXT-OF-KIN PHONE #

FINANCIALLY RESPONSIBLE PARTY

RESPONSIBLE PARTY NAME: LAST FIRST M.I. RESPONSIBLE PARTY HOME #
RESPONSIBLE PARTY ADDRESS CITY STATE ZIP RELATIONSHIP TO CLIENT
RESPONSIBLE PARTY EMPLOYER OCCUPATION (JOB TITLE) RESPONSIBLE PARTY WORK #
RESPONSIBLE PARTY EMPLOYER ADDRESS CITY STATE ZIP RESPONSIBLE PARTY SOCIAL SECURITY#

INSURANCE INFORMATION

PRIMARY INSURANCE POLICY HOLDER DATE OF BIRTH
IDENTIFICATION NUMBER GROUP NUMBER
CLAIMS ADDRESS CITY STATE ZIP PHONE NUMBER
SECONDARY INSURANCE POLICYHOLDER DATE OF BIRTH I.D. NUMBER GROUP NUMBER
CLAIMS ADDRESS CITY STATE ZIP PHONE NUMBER

Please Provide Primary Care Physician Information:

- I prefer my therapist coordinate care with my PCP.
I prefer my therapist not release information to my PCP.
I have no Primary Care Physician.

Dr's Name:
Dr's Phone #:
Dr's Fax #:
Dr's Address:

Please provide Psychiatrist Information:

- I prefer my therapist coordinate care with my Psychiatrist.
I prefer my therapist not release information to my Psychiatrist.
I have no Psychiatrist.

Psychiatrist Name:
Psychiatrist Phone #:
Psychiatrist Fax #:
Psychiatrist Address:

Signature Date