

# ALPHABET SHUFFLE, LLC

## CLIENT REGISTRATION FORM

*(Please Print Clearly)*

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Address \_\_\_\_\_  
*Street*

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ E-mail Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	<b>Are You:</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black / African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> More Than One Race <input type="checkbox"/> Other: _____	<b>Client's Driver's License Number:</b> _____	<b>Driver's License State:</b> _____

### Employment Information:

Employer's Name \_\_\_\_\_

City That You Are Employed In \_\_\_\_\_ State \_\_\_\_\_

### For a Child/Adolescent ~ School Information:

School Name \_\_\_\_\_

City That The School Is Located In \_\_\_\_\_ State \_\_\_\_\_

### Correspondence and/or bills should be mailed to:

Mom  Dad  Both Parents  Other \_\_\_\_\_

If Minor: **Dad** Or Legal Guardian:

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_  
*Street*

\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip*

Driver's License Number \_\_\_\_\_ Driver's License State \_\_\_\_\_

If Minor: **Mom** Or Legal Guardian:

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_  
*Street*

\_\_\_\_\_ *City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip*

Driver's License Number \_\_\_\_\_ Driver's License State \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Policy Holder's Address (If Different From Client's) \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Member ID Number \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_

Relationship to Client:  Self  Parent  Spouse  Partner  Other

**SECONDARY INSURANCE**

Policy Holder's Address (If Different From Client's) \_\_\_\_\_

Name of Insurance \_\_\_\_\_ Member ID Number \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_ Employer \_\_\_\_\_

Relationship to Client:  Self  Parent  Spouse  Partner  Other



Have you ever had counseling before?  Yes  No If yes, where? \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Briefly describe the reasons you are here today \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Signature of the Client/Legal Guardian**

\_\_\_\_\_  
Relationship to Client

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date