ALPHABET SHUFFLE, LLC

REGISTRATION FORM

(Please Print Clearly)

First Name _____ MI _____ Last Name _____

Date of Birth _____ Social Security Number_____

Home Address_____
Street

_____ _____ _____
City *State* *Zip*

For the following information, please check the appropriate box if Alphabet Shuffle, LLC is allowed to leave a confidential message or text at the numbers and/or e-mail address:

Home Phone: _____ □ Message □ Permission not granted

Cell Phone: _____ □ Message □ Text □ Permission not granted

Work Phone: _____ □ Message □ Text □ Permission not granted

E-mail address _____ □ Yes send email □ No send email

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

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_____

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

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Have you ever had counseling before? □ Yes □ No If yes, where? _____

How did you hear about our office? _____

I confirm that the above information is accurate and agree to immediately notify Alphabet Shuffle, LLC of any changes to my information.

_____ _____

Print Responsible Party Member's Name Relationship

_____ _____/_____/_____

Responsible Party Member's Signature Date