GRANT L. MARTIN, PH.D.

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CLIENT REGISTRATION FORM

Client Last Name ______________________________ First Name ______________________________ Middle Initial _________

Birthdate ______ / ______ / _________ Age _________ Social Security # ________________________ ☐Female ☐Male

(IF CLIENT IS UNDER 18) Grade ____________________________________ School ____________________________________

Address ____ City ____________________________ State, Zip _______________

Home Phone ____ Work Phone ____

Email _______________________________________ Employer, Occupation ____

INFORMATION OF SPOUSE, OR PARENT/GUARDIAN (IF CLIENT IS A MINOR)

Client Last Name ______________________________ First Name ______________________________ Middle Initial _________

Birthdate ______ / ______ / _________ Age _________ Social Security # ________________________ ☐Female ☐Male

Address ____ City ____________________________ State, Zip _______________

Home Phone ____ Work Phone ____

Email _______________________________________ Employer, Occupation ____

How were you referred to this office? ____

Primary Care Physician ____ Phone ___________________________

Emergency Contact ____ Phone ___________________________

PERSON RESPONSIBLE FOR BILL, IF NOT CLIENT

Name ____ Relationship to Client ____

Birthdate ______ / ______ / _________ Age _________ Social Security # ________________________ ☐Female ☐Male

Address ____ City ____________________________ State, Zip _______________

Home Phone ____ Work Phone ____

Email _______________________________________ Employer, Occupation ____

INSURANCE INFORMATION

Insurance Co. ___________________________________ Client's Relationship to Subscriber ☐Self ☐Spouse ☐Dependent

Subscriber ____ Birthdate ______ / ______ / _________

Subscriber ID # ____ Group # ____

Is insurance authorization needed? _________ Have you obtained? _________ What is your co-payment amount? _________

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the provider of service. I am financially responsible for any balance due. I also authorize the doctor/provider or insurance company to release any information required for this claim.

Client or Guarantor's Signature ____ Date ______ / ______ / _________

IMPORTANT: Payment is expected at the time of service. All balances due are payable within 30 days. Accounts with balances over 30 days will be charged a finance charge of 1% per month. Missed appointments and cancellations without 24 hours notice will be charged. Initial ___________