



REGISTRATION

Name: _____ Name I'd like to be called: _____

Age: _____ Date of Birth: _____ SS#: _____

Address: _____
Street address City State Zip

Home Phone: _____ Office Phone: _____ Cell Phone: _____

***Please indicate the phone number preferred for contact: _____

E-mail: _____ Referred by: _____

Highest Level of Education: _____ Occupation: _____

Employer: _____ Insurance Co.: _____

Insurance Policy Holder: _____ Their Date of Birth: _____

Marital Status: S M D Se W If Student-School: _____

Spouse: _____ Date of Birth: _____ SS#: _____

Address: _____

Home Phone: _____ Office Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Children (names & ages): _____

Personal Physician: _____ Phone: _____

Previous Psychologists (names & dates seen): _____

Current Medications: _____

Physical Illnesses: _____

Please explain the reason for seeking counseling or consultation: _____

I request consultation and evaluation by MEERS, INC. and I have read and agree to the terms of the "Statement of Office Policies" and the "Payment Policy" for my services. I have been informed of the Ohio HIPAA Notice Form and have been offered a written copy of the notice form.

Signature: _____ Date: _____

Signature: _____ Date: _____
(Witness)