Cynthia Bowling, LISW-S
2567 Erie Ave.
Cincinnati, OH 45208
(513)533-3500

CLIENT REGISTRATION FORM

Name (First) _____Middle Initial _____ Last _____

Address (Street) _____

(City) _____ (State) _____ (Zip) _____

Social Security Number _____ Dat of Birth _____/_____/_____

Gender (Please Circle) Female Male

Home Phone _____OK to leave a Message? _____Yes _____No

Work Phone _____ OK to leave a Message? _____Yes _____No

Cell Phone _____ OK to leave a Message? _____Yes _____No

Marital Status (Please Circle) Single Married Partnered Separated Divorced Widowed

Employment (Please Circle) Full Part Retired Disabled Student Other _____

Employer's Name _____

POLICYHOLDER AND INSURANCE INFORMATION

Policyholder's Name (First) _____ Middle Initial ____ (Last) _____

Policyholder's Address (Street) _____

(City) _____ (State) _____ (Zip Code) _____

Policy Holder's Social Security Number _____ DOB _____/_____/_____

Policy Holder's Relationship to Client (Please Circle) Self Spouse Partner Parent

Gender (Please Circle) Male Female

Policy Holder Home Number _____ Work _____

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Insurance Plan Name _____

Insured's ID Number _____Group Number _____

Employer"s Name (through which insurance is available) _____

Is there another Health Benefit Plan? If so, name _____

Responsible Party is (Please Circle) Self Spouse Partner Parent/

Guardian or Other (Please Specify) _____

Address (if different from client or policyholder) _____

City _____ State _____ Zip Code _____

Home Number _____ Work Number _____

Medical Information

Primary Care Physician (PCP) Name _____

Primary Care Physician Phone _____ Fax _____

Would you like your PCP notified of your participation in counseling? _____

If you answered yes, you will need to sign a release form to allow contact.

Emergency Contact Name _____Relationship to You _____

Emergency Contact Address _____

City _____State _____ Zip Code _____

Phone (Day) _____ Evening _____

How did you hear about my practice? _____

Permission to bill insurance company
By signing below, you give permission for this office to release information to your insurance company for the purposes of billing. Your signature also indicates that you have provided all the above information, including whether or not you would like your medical doctor to be notified of your participation in counseling.

_____ _____

Name ***Date***