Stacy Rankin Greco, MSW, LICSW
Psychotherapist

CLIENT REGISTRATION INFORMATION

Client Name: _____ DOB: _____

Address: _____

City, State, Zip Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Where Can Phone Messages Be Left: _____

Sex: _____ Marital Status: _____ Social Security #: _____

If Client A Minor, Provide Additional Parent/Guardian Contact Information If Different From Above: _____

_____

Emergency Contact: _____ Phone: _____

Relationship To Emergency Contact: _____

Who Referred You To This Therapist: _____

Please Indicate Your Preferences By Checking Below:

____ I prefer my therapist coordinate care with my Primary Care Physician (PCP)
____ I prefer my therapist coordinate care with my Psychiatry Provider (PP)
____ I prefer my therapist not release information to my PCP or PP at this time
____ I have no PCP
____ I have no PP

IF INDICATED, please sign additional Authorization For Release of Confidential Information form for your Primary Care Provider and/or Psychiatry Provider.

Client: _____ Date: _____
Parent/Legal Guardian: _____ Date: _____
Relationship to Client: _____

FOR OFFICE USE ONLY:
DX CODE: _____ Referred by: _____ Insurance Pay: _____ Self-Pay: _____