Kenneth L. DeSeve Ph.D. REGISTRATION FORM (Please Print)

Today's date:			PCP:			
CLIENT INFORMATION						
Client's last name: First: Middle:			Marital status (circle one) Single / Mar / Div / Sep / Wid			
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M	❑ F
Street address:		City:	State & ZIP Code:			
P.O. box:	Home phone no.: (OK to leave messages? Y / N) ( )	Cell Phone no.: ( )	Occupation:			
E-mail address:		Spouse's E-mail address:				
Spouse's Name:		Spouse's Birthdate: / /				
Children's Names & Ages:						
Religious Preferences: Involvement: 0 1 2 3 4 VERY		Referred to our Office by:				
INSURANCE INFORMATION						
(Please give your insurance card to the receptionist or Dr. DeSeve on your first visit.)						
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:(if different) ( )			
Employer:		Employer phone no.: (O.K. to leave messages? Y / N) ( )				
Primary insurance: (No Medicaid, Medicare or Secondary insurance is taken)						
Subscriber's name:	Birth date:	Policy No.:	Group no.:	Deduct. amt.: Deduct. Amt. met:	Co-payment: $	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Other:			
COUNSELING GOALS & MEDICAL HISTORY						
: Previous Counseling (if so, when & with whom)						
Pertinent Medical Issues: (If so, Physician, Treatment and Medications)						

Brief Description of major problems as you see them and Desired Solution or Goals for Therapy: