LISA M. STEPHEN, Ph.D., P.C.

Licensed Psychologist – Doctorate

89 Rye Circle, Suite 1 South Burlington, VT 05403 • Ph (802) 355-9299 • Fax (802) 419-3399

Client Last Name:	Client First Name:	DOB:	Date:

CLIENT REGISTRATION FORM - ADULT

Client Information

Name: _____ Date of Birth: _____ Soc.Sec. #: _____

Home Street Address:_____ City: _____ State: ____ Zip: _____

Home Phone:_____Work Phone: _____Cell: _____

Sex (write in male, female or another descriptor): _____

Drivers License number and state:_____ Ethnicity/Race:_____

Employer:_____ Occupation:_____

Insured's Information (If not client)

Name: _____ Date of Birth: _____

Street Address:_____ Home Phone: _____

City: _____ State: _____ Zip: _____

Sex (circle one): Male / Female Relationship to Client:_____ Employer:_____

Primary Insurance Carrier

Company:_____ Phone:_____

Street Address:_____ City: _____ State: _____ Zip: _____

Member #:_____ Group #:_____

Secondary Insurance Carrier (If additional policy is active, the information must be provided.)

Company:_____ Phone:_____

Street Address:_____ City: _____ State: _____ Zip: _____

Member #:_____ Group #:_____

Telephone and Written Communication

Dr. Stephen may leave telephone messages for me with her name, telephone number, and information related to appointment dates, times, and changes at the following telephone number(s):

Home: _____ Work: _____

Cell: _____ Other: _____

Dr. Stephen may send written correspondence to me at the following address:

Address: _____

City: _____ State: _____ Zip: _____

Emergency Communication

If there is an emergency or I become concerned about your personal safety, I am required by law and by the rules of my profession to contact someone close to you—perhaps a relative, spouse, or close friend—to protect you. I am also required to contact this person, the authorities, or someone you might hurt if I become concerned about your harming someone else. If you choose not to provide a contact person and/or to consent to my contacting others when there is a safety issue, I cannot work with you, and you will need to seek services elsewhere.

In the event of an emergency, I give Dr. Stephen permission to contact the following person(s) (at least one contact is required):

Name: _____ Relationship to you: _____

Address: _____

Home phone: _____ Cell: _____ Work: _____

Name: _____ Relationship to you: _____

Address: _____

Home phone: _____ Cell: _____ Work: _____

My signature below indicates that the information cited above is true, accurate, and current. My signature also indicates my permission for Dr. Stephen to contact me by phone and/or mail as indicated above and to notify the person(s) and professional(s) listed under Emergency Communication in an emergency.

	Signature	**Printed Name**	**Date**
Client			
Parent/Guardian			

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.