Michael A Emerson, PhD – Montana City Counseling
REGISTRATION FORM

(Please Print)

Today's date:	Primary Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	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:	Social Security No.:	Cell Phone No.: ( )

P.O. Box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose center because/Referred to center by (please check one box):	❑ Dr.	❑ Insurance Plan	❑ Internet

❑ Family	❑ Friend	❑ Work	❑ Yellow Pages	❑ Other

EMAIL ADDRESS:

INSURANCE INFORMATION

(Please give your insurance card to the clinician.)

Person responsible for bill:	Birth date: / /	Address (if different):	Cell phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No *If NO – fee agreement of* $ *has been made.*

Please indicate primary insurance	❑ BC/BC	❑ BC/BS Federal	❑ BC/BS State	❑ MUST	

❑ Blue Chip	❑ Tri Care	❑ EBMS	❑ Allegiance	❑ Other

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**	**Co-payment:** $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Emerson. I understand that I am financially responsible for my deductible and any balance. I also authorize Dr. Michael A Emerson – Emerson Consulting Inc. or insurance company to release any information required to process my claims.

Insured Deductible: $ ❑ Met ❑ Unmet

Patient/Guardian signature *Date*