Naper Clinical Behavioral Services
800 East Diehl Road • Suite 100 • Naperville, Illinois 60563
Office (630)577-1577 Fax (630)577-1555

Registration Form

Patient information: Please have Driver's License (or other photo I.D.) and Insurance Card ready to be copied.

Date _____ Date of Birth _____
Month Day Year

Patients Name _____

Home address _____
Street address City State Zip Code

Home # (_____) _____ Cell # (_____) _____ Work # (_____) _____

SSN# _____How did you find our practice? _____

Driver's license #_____

Employer _____

Spouse's Information:

Name: _____ DOB _____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

SS #_____ Driver's License # _____

Parent/Legal Guardian Information:

(If child/adolescent is under parent's/guardian's insurance policy and/or responsible for payment):

Mother's Name _____ DOB _____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

SS #_____ Drivers License # _____

Mother's maiden name _____

Father's Name _____ DOB_____

Home # (_____)_____ Cell # (_____)_____ Work # (_____)_____

SS #_____ Drivers License # _____

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With whom does the child/adolescent primarily reside? _____
Name

_____
Address *City* *Zip code*
*(_____)*_____
Phone number

Name of school adolescent attend? _____ Grade Level _____

School Counselor's name and phone number _____

Primary Health Insurance:

Insurance Company Name _____ Provider phone number (_____)_____

Identification # _____ Group # _____

Policy Holder Name _____ Relationship to patient _____

Policy Holder's Address_____

Policy Holder's Employer _____

Policy Holder's Date of Birth_____

Secondary Heath Insurance:
Insurance Company Name _____ Provider phone number (____)_____
Identification number_____ Group #_____
Policy Holder Name _____ Relationship to patient _____
Policy Holder address _____
Policy Holder Employer_____ Policy Holder Date of Birth_____

Please indicate the person financially responsible for account:

Name _____Relationship to patient _____

_____
Address

_____
City *Zip Code*