1032 Turnpike Street
Suite 204
Canton, MA 02021

Renz Counseling

378 Page Street
Suite 6
Stoughton, MA 02072

New Patient Registration Form

Note: All fields in **bold** are required. Please print clearly!

Clinician: _____ **Today's Date**: _____

PATIENT			
Last:	**First:**	Middle	
Address line 1:	☐ **Male** ☐ **Female**	**DOB:**	
Address line 2:	**City:**	**State:**	**ZIP:**
Email:	Do you want appointment reminders by email? ☐ Yes ☐ No		
Home phone:	**Cell phone:**	**Work phone:**	
OK to leave voice messages? ☐ Yes ☐ No	OK to leave Voice messages? ☐ Yes ☐ No OK to leave Text messages? ☐ Yes ☐ No	OK to leave voice messages? ☐ Yes ☐ No	
Preferred phone: ☐ Home ☐ Cell ☐ Work	**Marital status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed		

INSURANCE			
Primary Insurance:	Plan name:		
ID #:	Group #:	**Co-Pay: $**	
Secondary Insurance:	Plan name:		
ID #:	Group #:	Co-Pay: $	
Pre-Authorization (if applicable):	Authorization #:	Expires:	# of sessions:
Patient's Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other:			
If Insured is not the Patient, then all Insured's information below is required:			
Last:	First:	Middle	
Address line 1:	☐ Male ☐ Female	DOB:	
Address line 2:	City:	State:	ZIP:
Email:	Phone:		

EMERGENCY CONTACT			
Last:	**First:**	Middle	
Address line 1:		DOB:	
Address line 2:	City:	State:	ZIP:
Email:			
Home phone:	**Cell phone:**	Work phone:	
Relationship to Patient: ☐ Spouse ☐ Parent ☐ PCP ☐ Other:			

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the Provider of service to furnish information to insurance carriers concerning my condition and treatment. I hereby assign to the provider all payments for medical services rendered to my dependents or myself.
I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

Signature: _____ **Date:** _____