Victoria Whitetree, LSCSW
123 N. Tyler Road, Suite 300
Wichita, Kansas 67212
Phone 316.869.2224 Fax 316.869.2221

CLIENT REGISTRATION FORM

Patient Name_____
First Middle Last

Address_____

City _____ State_____ Zip _____ Birth Date _____

Phone: (Home) _____ (Work) _____ (Cell) _____

E-mail address if you would like appointment reminders :_____(please sign consent form)

SS# _____ Primary Care Physician_____

Place of Employment _____

Who Referred You To This Office?

_____

What concerns do you currently have and how would you like to benefit from therapy?

_____

_____

_____

_____

_____

_____

Responsible Party Information

Responsible Party _____
First Middle Last

Address _____

City _____ State _____ Zip _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Medical Insurance Information

Primary

Subscriber Name _____ SS # _____

Employer _____ Subscriber Date of Birth _____

Group Name _____Group Number _____ Relationship to Client _____

Individual Policy Number _____ Does this plan cover all family members? _____ Yes ____ No

Additional Medical Coverage: _____Yes _____ No

If yes, please complete the following:

Secondary

Subscriber Name _____ SS # _____

Employer _____ Subscriber Date of Birth _____

Group Name _____Group Number _____ Relationship to Client _____

Individual Policy Number _____ Does this plan cover all family members? _____ Yes _____ No

Assignment of Benefits

By my signature, I authorize payment of medical benefits to Victoria Whitetree, LSCSW, LLC.

Signed _____ Date _____
(Subscriber)

Release of Information

I authorize Victoria Whitetree, LSCSW, LLC to release information to my insurance company in order to process the claim.

Signed _____ Date _____
(Patient, or Parent if Minor)

Significant Medical Conditions

_____

_____

Past Medications

_____

Present Medications

_____

Family Member Information

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Psychiatric Hospitalizations? _____Yes _____No Legal Offenses? _____Yes _____ No

Family History – Medical or Psychiatric

_____

_____

_____

Religious Preference _____

Significant events you feel are relevant to your treatment:

Event	Date
_____	_____
_____	_____
_____	_____

I authorize Victoria Whitetree, LSCSW, LLC to provide mental health services. I authorize her to utilize the given e-mail address to communicate regarding appointments.

Signed _____ Date _____
(Patient, or Parent if Minor)