Ronald L. DeLong, Ph.D. & Associates, LLC Client Registration Form

PLEASE PRINT AND COMPLETE ALL ENTRIES

Client Name (first, MI, last) _____ Date of Birth _____ Social Security _____

Address (street, state, zip code) _____ Home/Cell Phone _____ Work Phone _____

_____ **(For Office Use Only)** Diagnosis: _____

Marital Status _____ Age _____ Sex _____

Race (circle one) White Black Native American Alaska Native Native Hawaiian/Other Pacific Islander

Other Single Race Two or More Races

Ethnicity (circle one) Puerto Rican Cuban Mexican Other Specific Hispanic Unknown Not of Hispanic Origin

Veteran Y N Religion _____

Military Status (circle all that apply) None Discharged Active Duty Disabled Veteran Afghanistan Veteran Iraqi Veteran

Please indicate phone# we should use to contact you: Home Work Can we leave a message? Yes No

Can we mail information? Yes No

Please note that electronic information can be sent if a secure site is utilized. You will need to set up an account with us if you want to receive information via this method. Do you want to receive information via email or text message? Yes No

Please note that before such information is sent, an account must be confirmed and a secure line established.

Number of Arrests (past ten years): _____

Number of people in household: _____ Do children live with you? _____

Family/Household Members:

Name: _____ D.O.B. _____ Relationship _____

Name: _____ D.O.B. _____ Relationship _____

Name: _____ D.O.B. _____ Relationship _____

Name: _____ D.O.B. _____ Relationship _____

Name: _____ D.O.B. _____ Relationship _____

Emergency Contact _____ Relationship _____ Phone _____

Emergency Contact Address: _____
(Phone number will not be called unless a medical emergency)

Physician Name:_____ Phone#_____

Physician Address:_____
If no Family Physician check here ( )

Insurance and Payment for Services

How Do You Intend To Pay For Services?

___Personal Insurance ____ Third Party Insurance ____ Self Pay or No Insurance (which)

Primary Insurance		**Secondary Insurance**	
Insurance name	_____	Insurance name	_____
Phone	_____	Phone	_____
Address	_____	Address	_____
City	_____	City	_____
Zip	_____	Zip	_____
ID Policy#	_____	ID Policy #	_____
Group #	_____	Group #	_____
Insured's name	_____	Insured's name	_____
Insured's Date of birth	_____	Insured's Date of birth	_____

Client or Authorized Person's Signature: I authorize payment of medical benefits to Ronald L. DeLong, Ph.D. & Associates, LLC and/or DeLong, Peterson & Associates, LLC. I authorize the release of any medical or other information necessary to process this claim or any further claims. I also request payment of government benefits either to myself or to the party who accepts assignment below. I authorize to Ronald L. DeLong, Ph.D. & Associates, LLC and/or DeLong, Peterson & Associates, LLC claims on my behalf. I authorize the release of any medical or other information necessary to process my claims. Signed_____ Date_____

Attach copies of front and back of insurance cards here, even if self pay.