David P. Knight, Ph.D., Clinical Psychologist
Client Registration

Client Information Date _____

Name _____ Male or Female _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work # _____ Cell # _____

Circle all numbers where I can leave a message

Personal Email Address _____

Birthdate _____ Social Security # _____

Primary Care Physician _____ PPC Phone _____

Employer _____ Employer Address _____

If you have chosen not to use Insurance, Sign here _____

Responsible Party (if not client)

Name _____Relationship _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Work # _____ Cell # _____

Personal Email Address _____ Social Security # _____

Employer _____ Employer Address _____

Emergency Contact

Name _____Relationship _____

Home Phone # _____ Work # _____ Cell # _____

Insurance Information

Primary Insurance _____ Policy I.D.# _____

Policy Holder Name _____ DOB _____ SS# _____

Address _____ City _____ State ____ Zip _____

Employer _____ Employer Phone # _____

Secondary Insurance _____ Policy I.D.# _____

Policy Holder Name _____ DOB _____ SS# _____

Address _____ City _____ State ____ Zip _____

Employer _____ Employer Phone # _____