



LAKE COOK
BEHAVIORAL HEALTH

NEW CLIENT REGISTRATION FORM

CLIENT INFORMATION (Please Print Clearly)

Name: _____ Client Home Phone: _____

Home Address: _____ Client Cell Phone: _____

_____ Client Date of Birth: _____

_____ Client Gender: Male Female (circle one)

Client marital status: _____ Client Employment status: employed/student (circle one)

BILLING INFORMATION (if different from above) :

Person responsible for bill: _____

Address : _____

Phone Numbers (home and cell): _____

INSURANCE INFORMATION:

Insurance Carrier: _____ Member ID# _____

Group #: _____ Provider services phone # _____

Primary Insured name: _____ Relationship to client: Self Spouse Parent (circle)

******Primary Insured Date of Birth: _____ (REQUIRED)**

EAP INFORMATION:

EAP Carrier: _____ Authorization # _____

Number of sessions authorized: _____

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