

# BEZZIO COUNSELING, PLLC

## Patient Registration

Please fill out all questions

Patient:(Last, First, MI)

Email:

If married, give spouse's name:

If child, give person responsible for bill:

Home Address:

Street:

City:

State:

Zip Code:

Preferred Phone number:

OK to leave message?

YES

NO

Patient's employer or school:

Birth Date:

In case of emergency:

Phone:

Health Insurance:

Group Number:

Members Insurance Number:

Referred to this office by:

Date:

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Patient's/Responsible Payer's Signature