Pacific Counseling Partners of Hawaii, LLC Lyann Sugai, MFT

Registration Form

Client's Name: _____ Date of Birth: _____

Social Security Number: _____ Gender (circle one): M F

Address: _____

City: _____ State: _____ Zipcode: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Employer: _____

Address: _____ Work Phone: _____

Email: _____

Marital Status (circle one): Single Cohabitating Married Separated Divorced

Spouse's Name: _____

Children in Family (names, ages, occupation): _____

Primary Care Physician (PCP): _____ Phone: _____

Current Medications: _____

Reason for visit: _____

Referred by: _____ May I thank this person? Yes___ No ___

Insurance Information:

*Please bring card to visit

Medical Insurance Company: _____

Membership Number: _____ Group Number: _____

Subscriber's Full Name: _____ Subscriber DOB: _____

Relationship to Subscriber: _____

Secondary Insurance Company: _____

Membership Number: _____ Group Number: _____

Subscriber's Full Name: _____ Subscriber DOB: _____

Relationship to Subscriber: _____

Complete if client is a minor:

Parent/Legal Guardian Name: _____

Address: _____ Phone: _____

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

Minor's School: _____ Grade: _____

I hereby consent and authorize to have Lyann C. Sugai, MFT of Pacific Counseling Partners of Hawaii, LLC, to make any and all insurance claims on my/our behalf. I understand that I am responsible for any amount not covered by insurance.

Signature: _____ Date: _____