



# SOUTH SHORE THERAPIES Client Registration

**FOR SST USE ONLY:**

CT verified by: \_\_\_\_\_

Outlook entered by: \_\_\_\_\_

Date: \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Parent/Guardian #1 \_\_\_\_\_ Relationship \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Check Preferred Phone : Home  Cell  Work 

Parent/Guardian #2 \_\_\_\_\_ Relationship \_\_\_\_\_

Email Address \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Address \_\_\_\_\_  
(if different from above)

Emergency Contact \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

PCP Name/Location \_\_\_\_\_

PCP Phone # \_\_\_\_\_

Primary Insurance Policy Holder's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Is there Secondary Ins Policy? Yes  No  If yes, Policy Name/# \_\_\_\_\_