



**BARBARA L. EDWARDS, M.A. - LICENSED PSYCHOLOGIST**

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**NEW CLIENT REGISTRATION**

NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE: HOME \_\_\_\_\_  
WORK \_\_\_\_\_  
CELL \_\_\_\_\_

EMPLOYER \_\_\_\_\_

IF INSURANCE IS THROUGH A SPOUSE OR PARENT

NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS (IF DIFFERENT) \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

EMPLOYER \_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

EMERGENCY CONTACT

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

PHYSICIAN \_\_\_\_\_