THE MERITE GROUP LLC
...DISCOVER YOUR STRENGTHS!

11606 Southfork Ave., Suite 101
Baton Rouge, LA 70769
225-432-4955
www.themeritegroup.com

PATIENT REGISTRATION FORM

Please provide the following information. Please note that information you provide here is ***protected as confidential information***.

PATIENT INFORMATION

Patient Name (first, middle, last): _____ Nickname? _____
Address ☐ Physical address or ☐ Mailing address
Address _____
City _____ State _____ ZIP _____
Date of Birth: _____ Age: _____ Patient's SSN: _____
Cell Phone: _____ May we contact you here? ☐ YES ☐ NO
Home Phone: _____ May we contact you here? ☐ YES ☐ NO
Work Phone: _____ May we contact you here? ☐ YES ☐ NO
E-Mail: _____ May we email you? ☐ YES ☐ NO
Please note: Email correspondence is not considered to be a confidential medium of communication.

Occupation? _____ Religious Preference? _____

Patient RACE? ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black ☐ Hawaiian/Pacific Islander
☐ White ☐ Other Race _____ ☐ Unknown ☐ Declined
Patient ETHNICITY? ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Declined

Patient is ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Spouse's information (if applicable)
Name _____ Occupation _____ Date of Birth _____

IN CASE OF EMERGENCY

Emergency Contact for Patient: _____ Relationship to Patient? _____ Phone: _____

INSURANCE POLICY INFORMATION (*if applicable*)

PRIMARY INSURANCE
Policy/Contract No. _____
Group No. _____
Name of Policy Holder _____
Employer _____
Policy Holder's Soc. Sec. No. _____
Policy Holder's Date of Birth _____

SECONDARY INSURANCE
Policy/Contract No. _____
Group No. _____
Name of Policy Holder _____
Employer _____
Policy Holder's Soc. Sec. No. _____
Policy Holder's Date of Birth _____

By signing below, I AUTHORIZE THE RELEASE OF INFORMATION necessary to process my insurance/ EAP/ managed care/ DDS claim (if applicable) and I ACKNOWLEDGE FINANCIAL RESPONSIBILITY for this account.

PATIENT SIGNATURE _____ DATE _____

Please note:
Please complete online or print and fill out this form (PATIENT REGISTRATION/INFORMATION) and bring it to your first session. If you do not fill these out in advance, please plan to be to your session 20 minutes before the start of your first appointment and we will provide a printed copy to complete at our office.

For your initial appointment please bring your Driver's License/State issued ID Card and your insurance card(s).

Please share how you heard about us? _____