

**Macks Psychology Group
Adult Patient Registration Form**

Patient Information

Patient Name: _____ Birthdate: _____
Street Address: _____
City, State, Zip: _____ County: _____
Gender: _____ Phone Number: _____ cell home business (circle one)
Email Address _____ School or Employer: _____
Marital Status: ___ Single ___ Married ___ Separated/Divorced ___ Other
Primary Care Physician: _____ Physician Phone #: _____
Referral Source: Physician School Employer Insurance Company Internet Search
Friend Other: _____

Reason for Appointment

Please check the primary reason(s) for which you have requested this appointment:

<input type="checkbox"/> Academic or learning struggles	<input type="checkbox"/> Defiance or oppositional behavior
<input type="checkbox"/> Job performance struggles	<input type="checkbox"/> Anger, aggression or tantrums
<input type="checkbox"/> Attention, focus or memory problems	<input type="checkbox"/> Mood/Depression concerns
<input type="checkbox"/> Hyperactive, overly talkative or impulsive	<input type="checkbox"/> Anxiety, fear or worry
<input type="checkbox"/> Speech/Articulation struggles	<input type="checkbox"/> Grief/Loss
<input type="checkbox"/> Language/Communication struggles	<input type="checkbox"/> Stress management
<input type="checkbox"/> Social difficulties	<input type="checkbox"/> Coping with physical pain/illness
<input type="checkbox"/> Adherence to medical needs	<input type="checkbox"/> Sensory processing/sensory integration
<input type="checkbox"/> Fine motor and/or coordination	Other _____

Insurance Information

Primary Insurance Carrier: _____
Policy ID #: _____ Group #: _____
Policy Holder's Name: _____ Relationship to Patient: _____
Policy Holder's Date of Birth: _____
Policy Holder's Address (if different from patient's): _____
Policy Holder's Phone Number (if different from patient's): _____
Policy Holder's SSN: _____ Policy Holder's Employer: _____
Secondary Insurance Carrier (if applicable): _____
Secondary Insurance Policy ID#: _____ Group #: _____
Secondary Insurance Policy Holder's Name: _____