Max Psychiatry

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Patient Registration Form

Patient Demographics

First Name_____ Last Name _____MI _____
Address _____Apt. # _____
City_____ State _____Zip Code _____
Phone (Home) _____ Phone (Cell/Work) _____
Date of Birth _____Gender: Male _____ Female _____
Social Security Number _____ Email ID_____
Emergency Contact _____ Phone_____
How did you hear about us _____
Occupation _____Employer_____

Insurance Information

Primary insurance

Person Responsible: Self _____ Spouse_____ Child _____Other _____
Policy Holder Name _____ Date of Birth_____
Address (if different from patient's)_____
City_____ State_____ Zip Code _____
Insurance Company _____ Group # _____
Subscriber # _____ Employer _____
Occupation _____ Social Security Number _____

Secondary insurance (if applicable)

Person Responsible: Self _____ Spouse_____ Child _____Other _____
Policy Holder Name _____ Date of Birth_____
Address (if different from patient's)_____
City_____ State_____ Zip Code _____
Insurance Company _____ Group # _____
Subscriber # _____ Employer _____
Occupation _____ Social Security Number _____

I hereby authorize the doctor to release all information necessary to secure all payments of benefits. I understand that I am financially responsible for all charges whether paid or not paid by my insurance company. I authorize the use of this signature on all insurance submissions.

_____ _____
Signature of Responsible Party Date