TERI WRIGHT, Ph.D.
2101 N. Main St., Ste. D., Santa Ana, CA 92706 714 558 8487

REGISTRATION

PATIENT NAME _____

DATE OF BIRTH _____AGE_____GRADE IN SCHOOL_____
ADDRESS
STREET_____APT._____CITY_____STATE_____ZIP_____

EMAIL ADDRESS: _____

TELEPHONE *(Please circle Y or N to indicate whether or not I may leave a message.)*

	HOME	CELL	WORK
PATIENT	_____Y N	_____Y N	_____Y N
MOTHER	_____ Y N	_____Y N	_____Y N
(Mother's name and phone #s if patient is a minor)			
FATHER	_____Y N	_____Y N	_____Y N
(Father's name and phone #s if patient is a minor)			
OTHER	_____Y N	_____Y N	_____Y N

INSURANCE COMPANY_____PHONE_____

INSURANCE COMPANY ADDRESS_____

SUBSCRIBER_____DATE OF BIRTH_____

ADDRESS OF SUBSCRIBER (if different from patient's)_____

IDENTIFICATION #_____GROUP #_____

EFFECTIVE DATE_____EMPLOYER_____

PERSON RESPONSIBLE FOR ACCOUNT_____

DO YOU HAVE SECONDARY INSURANCE? Y N
(If you have secondary insurance, please write the same information on the back of this page.)

ASSIGNMENT OF BENEFITS

I agree to assign to Dr. Wright all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Wright may use health care information and may disclose such information to the above named insurance company(ies), their agents, and Dr. Wright's billing service for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services. The consent will end when my current treatment is completed.

I acknowledge that I have read and agreed to Dr. Wright's Office Policies.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____

PLEASE PRINT NAME_____DATE_____RELATIONSHIP TO PATIENT_____

PERSONAL AND MEDICAL HISTORY

Marital Status_____

Children (# and ages)_____

Current Medications

Prescription_____

_____

Other_____

_____

Have you ever received psychiatric, psychological, or substance abuse treatment? YES NO

Outpatient (approximate dates)_____

Inpatient (approximate dates)_____

Have you ever taken medication for a psychiatric or psychological condition? YES NO

Type or Name of Medication_____

_____

Primary Care Physician, Pediatrician, and/or Psychiatrist

Name_____

Address_____

Telephone_____

Referred by_____

Additional Comments or Information

_____

_____

_____

Name Signature Date

_____

Name of Parent or Guardian (if patient is minor) Signature Date