PsychNP Wellness Center, LLC.
658 Kenilworth Drive Suite 206
Towson, MD 21204
Phone: (443) 841-7550 Fax: (443) 841-7572

New Patient Registration Form

Date:_____ Unique Patient ID: _____

Patient Information

Patient Full Name: _____

Home address: _____

City: _____ State: _____ Zip: _____

Phone Number: Home: _____ Work: _____ Cell: _____

Email: Primary:_____ Secondary: _____

Employment: employed full time student part time student disabled unemployed retired

Employer or School: _____ Grade: _____

Marital Status: Single Married Divorced Divorce Pending Widowed Engaged Partnered Separated

Date of Birth: _____ Gender: Male Female SSN: _____

Insurance Information

- I am not using any insurance (self-pay) *skip this section*

Insurance: _____ Policy Number: _____ Group: _____

Policy Holder: Patient Patient's Parent or Guardian Patient's Spouse

If someone other than yourself is the insured party, please fill out the following section

Name: _____ Phone: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Employer: _____

Secondary Insurance (if applicable):

Insurance: _____ Policy Number: _____ Group: _____

Policy Holder: Patient Patient's Parent or Guardian Patient's Spouse

If someone other than yourself is the insured party, please fill out the following section

Name: _____ Phone: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Employer: _____

Primary Care Provider

Physician: _____ Phone Number: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Other/Secondary Doctor: _____ Phone Number: _____

Practice Address: _____

City: _____ State: _____ Zip: _____

Referred By: _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Person Responsible for PsychNP Wellness Bills

(Complete only if different from patient)

Name: _____ Phone: _____

Relationship: _____ Date of Birth: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Assignment of Benefits

l, the undersigned, assign to PsychNP Wellness Center LLC all medical benefits, and authorize the release of this signature for all claim submission to my insurance company, including Medicare and/or Medicaid. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the facility and the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that health insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible or payment of all services, covered and non-covered. I understand that if I terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable.

_____ _____

Signature of Patient/Client (Parent or Guardian if minor child) Date