Erin Jacobson, ARNP
12 Bellwether Way STE 223, Bellingham WA 98225
Ph. (360)707-7608 FAX (360)707-7648 kidspsychiatry.com

Registration and Demographics

Today's Date: _____Please indicate: _____I am a new patient **OR** _____I am updating information

Referring Therapist Name and Phone number: _____

Patient's Name:_____Preferred Name:_____

Age: _____ DOB: _____ Gender: _____ Sexual Orientation: _____ SSN:_____

Person Completing this form and relationship to patient: _____

Name of legal guardian (if not person completing this form): _____
Child lives with:_____

Home Address_____

Home Ph #:_____ Work #_____ Email:_____
Please circle your preferred contact number and initial if it is OK to leave confidential information at that number.

Employer: _____

Primary Insurance Company: _____Phone:_____

Subscriber's Name: _____ DOB:_____

Subscribers ID #:_____Group #:_____

Secondary Insurance Company: _____ Phone_____

Subscriber's Name: _____ DOB:_____

Subscribers ID #: _____Group #:_____

Is an authorization or referral required by your insurance company for mental health coverage? _____Yes _____No

If you have an annual deductible how much have you met at this time? _____

How much is your co-pay or co-insurance for appointments? _____

Authorization of Payment
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits, as applicable and I authorize payment by my insurance company to provider, Erin A. Jacobson, MN, ARNP for services provided:

Signature:_____ Date:_____