Patient Registration Form

Please give the receptionist your ID and Insurance card so she can make a photocopy

Name________________________________ DOB______________

SSN________________ Age________ Gender ◯Male ◯Female

Address____
(street, city, state, zip)

Main Phone______________________ Ok to leave a message? ◯Yes ◯No

Does this number receive text messages? ◯Yes ◯No

Email ____
(not used for promotional purposes- Only for intended communication)

Occupation____________________ Employer/School________________

How did you hear about our office?

____

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EMERGENCY CONTACT

Name__________________________ Phone number________________

Relationship to patient______________________

MEDICAL & INSURANCE INFO

Are you under the care of a primary care physician? ◯ Yes ◯No

If yes, by whom?________________________Phone______________

Person financially responsible for services rendered at our practice?______________

Their address____________________________ Phone____________

Relationship to pt. ________________________

Please continue on next page

Insurance Information

Insurance Company________________________ ID #________________________

Subscriber Name________________________ DOB________________________
Person who carries insurance

Address____
(street, city, state, zip)

Phone #________________________ Relationship to Pt.________________________

Do you know your Copay or coinsurance for *OUTPATIENT MENTAL HEALTH* services?
If yes, how much is it________________________

I authorize release of any information concerning my (or my minors) health care, avice and treatment provided for the purpose of evaluating and administering claims or insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

________________________________ ________________
Signature of patient (or guardian) *Date*

*** A Credit card authorization form is included in this packet if youd like to keep a card on file to cover copays or balances on your account. It is optional but recommended, and can be terminated at anytime***

Secondary Insurance

Insurance Company________________________ ID #________________________

Subscriber Name________________________ DOB________________________

Address____
(street, city, state, zip)

Phone #________________________ Relationship to Patient________________________

Do you know your Copay or coinsurance for *OUTPATIENT MENTAL HEALTH* services?
If yes, how much is it________________________

I authorize release of any information concerning my (or my minors) health care, avice and treatment provided for the purpose of evaluating and administering claims or insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

________________________________ ________________
Signature of patient (or guardian) *Date*

Signature

Date