Patient Registration Information

PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

Patient Name:	Home Phone: ( )	Date of Birth / /	Age:
Address:	Gender (birth/biological): Male Female Other	Social Security Number:	
City:	State:	Zip Code:	Marital Status: Single / Married / Widowed Divorced / Remarried / Co-habitating
Employer:	Occupation:	Work Phone :	
Race:	Religion:	Primary Care Provider:	

RESPONSIBLE PARTY / PRIMARY CARD HOLDER

Name:	Date of Birth: / /	Social Security No:	Relationship:	Home Phone: ( )
Address:	City:	State:	Zip Code:	
Employer:	Occupation:	Work Phone: ( )		

NOTIFY IN CASE OF EMERGENCY

Name:	Relation:	Home Phone:	Work Phone:
Address:	City:	State:	Zip:

REFERRED BY

Provider:	Family Member: Father / Mother / Brother / Sister Daughter / Son	Other: Father-In-Law / Mother-In-Law / Brother-In-Law Sister-In-Law / Daughter-In-Law / Son-In-Law Niece / Nephew / Cousin / Friend

INSURANCE INFORMATION

Primary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:
Secondary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:

Our office provides the service of a courtesy reminder call the day before your appointment. To protect your privacy, please indicate how you would prefer this to be done (please check any of the following):

- ❑ Leave a message at your home phone number.
- ❑ Call you at your work / alternate phone number:_____
- ❑ You prefer that staff does not confirm your appointment.

Our office requires that you notify us of a cancellation no later than the business day (before 12:00pm) prior to your scheduled appointment. Failing to do so results in you having to pay a $50.00 late charge if you are seeing a therapist or a $100.00 late charge if you are seeing a physician (Insurance does NOT pay for this). Not receiving a call will NOT excuse a missed appointment.

PLEASE READ AND SIGN:

I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefit to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any service defined as a non-covered service, I will be responsible for any amount due.

SIGNED:_____ DATE:_____/_____/_____