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PATIENT REGISTRATION INFORMATION - RESPONSIBLE PARTY INFORMATION

Today's Date:_____________

Patient's relationship to responsible party: Self ___Spouse ___ Dependent ___

If you are the responsible party, mark "self" and move down to "Insurance Information".

Last Name: ___________________________ First Name: ____________________ MI: _______________

Social Security No.: ___________________ Date of Birth: ___________________ Age: ______________

Street Address: ______________________________ City: ___________ State:_______ Zip: ____________

Phone Number(s): Home: _______________ Work: __________________ Cell: ___________________

E-mail Address: ____________________________________ Referred by: __________________________

Sex: M __ F__ Marital Status: Single __ Married __ Widowed __ Other__

Employer ____

Employer's Address:____ Occupation: ______________

PRIMARY HEALTH INSURANCE INFORMATION

Primary Health Insurance Company: ____

Policy Holder: ________________ Patient's relationship to Insured: Self __ Spouse __ Dependent__

Policy Holder's Date of Birth: ____________

Contract #: _________________________________ Group# _____________________________________

Insurance Carrier's Phone Number{s) for Mental Health Benefits: ________________________________

SECONDARY HEALTH INSURANCE

Secondary Health Insurance Company: ____

Policy Holder: ________________ Patient's relationship to Insured: Self __ Spouse __ Dependent__

Policy Holder's Date of Birth: ____________

Contract #: _________________________________ Group# _____________________________________

Insurance Carrier's Phone Number{s) for Mental Health Benefits: ________________________________