PSYCHIATRIC ASSOCIATES

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PATIENT REGISTRATION

NEW PATIENT ☐ **RECORDS UPDATE** ☐

Today's Date:______________

PATIENT INFORMATION:

Patient Name: ____

Address: ______________________________ City: ______________________ State:______________

Zip: ______________

Mailing Address [check this box if same as above] ☐ :____

City: __________________________________ State: __________________ Zip:__________________

Phone: (home) ____________________ (work) _____________________ (cell) __________________

Social Security Number: _____________________________ Gender :____________ Race:_____________

Date of Birth: ______________________ Age:_______ Driver's License Number: __________________

Place of Employment:__________________________ Position: __________________ How long: _____

Name of School (if student):____ Grade:_____________

Circle last year of school completed: 9 10 11 12 GED College: 1 2 3 4

Other: ____

In Case of an Emergency, who may be notified (other than someone living with you): __________________

______________________________ Relationship to Patient:________________________________

Phone: (Home) ______________________________ (Work) _________________________________

Who referred you to this office? ____

Responsible Party [Check this box if same as above] ☐

Name/Last: ____________________________ First: _______________________ MI :____________

Social Security Number: _________________________________ Date of Birth: ____________________

Mailing Address: ___________________________________ City:__________________ State: _______

Zip: _________________ Phone: (Home) _______________________ (Work) ____________________

(Cell) ___________________________Relationship to Patient: __________________________________

Responsible Party Spouse's name: ____

RP Spouse's SSN:____

Phone: (Home) ________________________________ (Work) ____________________________________

*SKIP THIS SECTION IF WE COPIED YOUR CARD

Insurance Information

Primary Insurance Company: ____

Insured Name: _________________________________DOB:________/_________/__________

Patient relationship to Insured: ____

Policy # ___________________________________ Group # ______________________________________

Employer: __________________________________

Secondary Insurance Company: ____

Insured Name: ________________________________DOB:_________/_________/___________

Policy # ______________________________ Group#_______________________________

Relationship to insured: _______________________Insured Employer: ___________________________

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on my insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance, and other health plans to the practice named on this form. This assignment will remain in effect until revoked by me in writing. A photocopy of this original is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

___________ ______________________________________

Date **SIGNED (Patient or Legal Guardian)**

PSYCHIATRIC ASSOCIATES

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