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Adult Psychiatry

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Registration Form

Date: ____________________________

Last Name: ______________________ First Name: ________________ MI: ________________

Age: ____________________________ DOB: ______________________ Marital Status: S M D

Other ________________

Whom should we thank for referring you?

Full Home Address: ____

Full Work Address: ____

E-mail Address:

Home Phone: ___________________ May confidential messages be left at this number? Y N

Mobile Phone: _________________ May confidential messages be left at this number? Y N

Work Phone: ___________________ May confidential messages be left at this number? Y N

Occupation: ________________________________ Employed By: ____________________________

SS #: ____

Driver's License Number and State: #__________________________ State: __________________

Health Insurance Company: ____

Insurance Member ID: Group ID:

Pregnant? Y N Birth Control: Y N

If yes, which: ____________________________

Medication Allergies? Y N

If yes, explain ____

Emergency Contact: ____

Address and Phone:

Primary Care Physician (or practitioner): ____

Address and Phone: ____

Therapist (if applicable): ____

Address and Phone: ____

Pharmacy Name: ____

Pharmacy Phone:

I give permission to release necessary information to my insurance company for billing purposes. I understand that I am to give a 24-hour notice if I cancel an appointment, otherwise I will be billed 50% of hourly rate for the missed session. The insurance company cannot be billed for missed appointments.

Signed____ Date ________________________________