Bob Oberlander, LMHC

PATIENT REGISTRATION FORM **DX Code(s):** _____

(Please complete all areas of form)

PATIENT INFORMATION

Patient Name: _____ **Sex: M [ ] F [ ]**

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home: (_____) _____ **Work: (_____)** _____

SS#: _____ **Date of Birth:** _____ **Employer:** _____

Occupation: _____ **Name of Spouse/partner (if applicable):** _____

Person to contact in event of emergency: _____ **Phone#:** _____

PERSON RESPONSIBLE FOR PAYMENT (IF NOT PATIENT): _____

Billing Address with City/Zip Code: _____

Phone# Hm: _____ **Wrk:** _____ **Relationship to patient:** _____

Employer: _____ **SS#:** _____

INSURANCE INFORMATION (Complete in full and provide a photocopy of your card)

Subscriber: _____ **Relationship to patient:** _____

Name of Insurance company: _____

Address: _____

Phone #: _____ **Group #:** _____ **ID#:** _____

Is this a managed care plan? YES [ ] NO [ ] Have you obtained authorization? YES [ ] NO [ ]

Name of Managed Care Company: _____ **Phone#:** _____

Do you have a referral from your primary physician? YES [ ] NO [ ]

Name of primary physician: _____ **Phone #:** _____

REFERRAL SOURCE

Name of person referring you to this office: _____

I, _____, have been given a handout explaining the services and policies of this office. I have had the opportunity to discuss any concerns or questions that I might have. I understand my rights and my responsibilities as outlined in the above-mentioned handout.

Patient and/or Guardian Signature: _____ **Date:** _____