Julie Behrens, PsyD

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:** ____________