Behavioral Health Care, P.C.

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REGISTRATION FORM

Today's date:					PCP:				
PATIENT INFORMATION									
Patient's last name:	First:	Middle:	Mr. Mrs.	Miss Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid				
Is this your legal name?	If not, what is your legal name?	Pharmacy:	Birth date:	Age:	Sex:				
Yes / No			/ /		M	F			
Street address:	Social Security no.:	Home phone no.: ( )							
P.O. box:	City:	State:	ZIP Code:						
Occupation:	Employer: Address:	Employer phone no.: ( )							
Chose clinic because/Referred to clinic by (please check one box):	Dr.	Insurance Plan	Hospital						
Family	Friend	Close to home/work	Yellow Pages	Other					
Names of family members seen here:									
INSURANCE INFORMATION									
(**Please give your insurance card to the receptionist**.)									
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )						
Is this person a patient here?	Yes	No							
Occupation:	Employer:	Employer address:	Employer phone no.: ( )						
Is this patient covered by insurance?	Yes	No							
Please indicate primary insurance	Medicare	BCBS	Meridian Medicaid	Cofinity	Priority Health (PPO & HMO)				
Aetna	Rail Road Medicare	AARP	*ASR Health*	Other					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $				
Patient's relationship to subscriber:	Self	Spouse	Child	Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:						

Patient's relationship to subscriber:	Self	Spouse	Child	Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my insurance company to release any information required to process my claims.

	Patient/Guardian signature		*Date*	