BALANCE BEHAVIORAL HEALTH, PLLC

PATIENT REGISTRATION FORM

All Forms must be completed before being treated

Date: _____/_____/_____

Patient Information:

First Name: _____ MI: _____ Last Name: _____

Address: _____ City: _____ ST: ___ Zip Code: _____

Home/Cell Phone: (_____) _____-_____ DOB: _____/_____/_____

Gender (Circle One): Male Female Other Marital Status (Circle One): Single Married Divorced Widowed

Email: _____Employer/School: _____

Parent/Legal Guardian (17 y/o or younger):

Name: _____ Home /Cell Phone: (_____) _____-_____

Emergency Contact:

Name: _____ Phone#: (_____) _____-_____Relationship_____

Guarantor Information (Responsible Party):

First Name: _____ MI: ___ Last Name: _____ SSN: _____

Address: _____ City: _____ ST: ___ Zip Code: _____

Home Phone: (_____) _____-_____ DOB: _____/_____/_____

Email: _____ Employer: _____

People Authorized to Act on Your Behalf (Make or cancel appointments):

Parent or Other: _____ Phone Number: (_____) _____-_____

Spouse/Significant Other: _____ Phone Number: (_____) _____-_____

Primary Care Physician Information:

Physician's Name: _____ Phone: (_____)_____

Office Address: _____

Is it alright to contact this physician with treatment information and updates? Yes / No

Insurance Information: ***(We will need to make a copy of your insurance card)***

(1) Social Security Number (required for treatment): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

(2) Primary Insurance: _____ Phone: (_____) _____-_____

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

Relation to Patient (Circle One): Self Spouse Parent Other

(3) Secondary Insurance: _____ Phone: (_____) _____-_____

Policy Holder Name: _____ Policy Holder DOB: _____/_____/_____

Relation to Patient (Circle One): Self Spouse Parent Other