BALANCE BEHAVIORAL HEALTH, PLLC

PATIENT REGISTRATION FORM

All Forms must be completed before being treated

Date: _____/_____/_____

Patient Information:

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

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

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

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

Email: _____Employer/School: _____ _

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

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

Emergency Contact:

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

Guarantor Information (Responsible Party):

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

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

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

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

Email: _____ Employer: _____

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

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

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

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

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

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

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