Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name:	Name:
First Name:	Address:
Middle Name:	
Address:	Relationship to patient: _____
City: State:	Date of Birth:
Zip:	Social Security No.:
Home Phone:	Phone: ( ) _____ - _____
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex:	Relationship:
Date of Birth:	Phone:
Social Security No.:	Mobile Phone:( ) _____ - _____
Patient email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language:	Employer:
Race:	Address:
Ethnicity:	Phone:
Marital Status:	

Other	Pharmacy Information:
Patient Referred by:	Name:
Primary Care Provider:	Street Address:
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Phone:

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name:	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

Please sign and date the items below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY PLLC**
- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**
- **I authorize PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY PLLC to release medical information required to process my claim**
- **I have read and understand the Financial Policy for PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY PLLC and that I am financially responsible for all non-covered services, copays, deductibles and/or co-insurance. I authorize and give consent for my provider to bill me for directly for recommended services performed that are not covered by the terms of my health plan**
- **I authorize PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY PLLC to obtain my medication history**
- **A fee for no-shows may be applied**
- **I authorize PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY PLLC to contact me by phone**
- **To the best of my knowledge, the above information is complete and accurate.**

Signed_____ **Date:**_____