FREEDOM BEHAVIORAL HEALTH SERVICES

REGISTRATION FORM

Today's date: (Please Print)

PATIENT INFORMATION

Patient's last name: First: Middle: Complaint or reason for seeking services:_____ _____	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F
Street address:		Social Security no.:		Home phone no.: ( )	
P.O. box:	City:		State:	ZIP Code:	
Occupation:	Employer:			Employer phone no.: ( )	

Primary Care Physician: Phone Number: ( )

***ALLERGIES:** ❑ None ❑ Food Allergies: _____ ❑ Medication Allergies: _____

Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Agency ❑ Name of Referral Contact:

Address:_____ City, State, & Zip:_____ Phone:_____Fax:_____

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 client here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this client covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

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 Freedom Behavioral Health Services. I understand that I am financially responsible for any balance. I also authorize Freedom Behavioral Health Services or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Parent/Guardian Name
(please print)