

SPECTRUM BEHAVIORAL HEALTH

REGISTRATION FORM

(Please Print)

Today's date:				Primary Care Physician:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Chose SBH because/Referred by (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:							
FINANCIAL RESPONSIBILITY							
(Please give your insurance card and photo ID to the receptionist.)							
Person financially responsible for bills:		Birth date: / /	Address (if different):			Home phone no.: ()	
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Social Security Number:			Driver's License Number:				
INSURANCE INFORMATION							
Primary insurance carrier			Mental Health Benefits Carrier				
Subscriber's name:	Subscriber's S.S. no.:		Birth date: / /	Group no.:		Policy no.:	Co-payment: \$
Subscriber's Occupation:	Employer:		Employer address:			Employer phone no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):			Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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 have acknowledge receipt of a copy of SBH's "Notice of Privacy Policies & Practices".							
_____ <i>Patient/Guardian signature</i>				_____ <i>Date</i>			
_____ <i>Clinician Review</i>				_____ <i>SBH Staff Review</i>			