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Clinical-Health Psychology

Patient Registration Form

Patient Name: _____ Date: _____
Last First MI

Address: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Soc. Sec.# _____

Sex: ___ Male ___ Female ___ Transgender

Whom may we thank for referring you? _____

Race/Ethnicity *(Check all that apply):*
___ American Indian/Alaskan Native ___ Asian ___ African American ___Caucasian ___ Hispanic
___Other: _____

Marital Status: ___ Single, never married ___ Married, living together ___ Married, not living together

___ Cohabitating with Partner ___ Separated ___ Divorced ___ Widowed

If you are married or cohabitating with partner, how long has this been? _____years _____months

Total number of marriages? ____ How many children do you have? _____

Spouse's/Partner's name: _____ What is your spouse's occupation? _____

Who else lives with you? _____

How many years of formal education have you completed? _____

Highest degree obtained *(Check only one)*: ___ High School Diploma ___ GED ___ 2 year college degree

___ 4 year college degree ___ Master's degree ___ Ph.D. ___ JD ___ MD ___ other: _____

What best describes your current employment status? *(Check one in each category)*

___Student ___Volunteer ___Unemployed, not looking for employment ___Unemployed, looking for

employment ___Full-time employed ___Part -time employed ___Retired ___Social Security Disability

What is your occupation? _____ Employer: _____

Emergency Contact:

Name: _____ Phone #: _____ Relationship: _____

Your Medical History

Are you allergic to any medication or food? If so, please list: _____

Are you allergic to anything else? (Latex, Insects, dust, etc.): _____

Please list your current and previous medical problems:

Allergy: ___ Asthma ___ Allergic Reactions ___ Other: ___

Cancer: Where or what type? _____

Cardiovascular: ___ Heart Failure ___ High Blood Pressure ___ Other: ___

Endocrine: ___Diabetes ___ Thyroid ___ Hormone Imbalance ___ Other: ___

Gastroenterology: ___ Stomach Ulcer ___ Reflux ___ Bowel ___ Other: ___

Hematology: ___ Blood disorders ___ Blood clots ___ Other: ___

Infectious Disease: ___ Hepatitis ___ Tuberculosis ___ HIV ___ Other: ___

Neurological: ___ Seizures ___ Stroke ___ Migraine Headaches ___ Other: ___

Nephrology: ___ Kidney Disease ___ Hypertension ___ Other: ___

Rheumatology: ___ Arthritis ___ Fibromyalgia ___ Gout ___ Other: ___

Respiratory: ___ Asthma ___ COPD ___ Sleep Apnea ___ Other: ___

Vision or Hearing Problems: ___

Other physical problems, not mentioned above: _____

_____

Please list all current medications below. Include prescription drugs, vitamins, birth control pills, herbal remedies, decongestants, etc.:

Name of Medication	Dose	Condition	Date started	Prescriber

Person Responsible for Payment on Account

Will you be using health insurance to pay for part of your visit(s)? ___ Yes ___ No

Patient's Relationship to Insured: ___ Self ___ Spouse ___ Child ___ Other: _____

Name of Insurance Company: _____

If the patient is not the insurance policy holder, please complete questions below.

Policy holder: _____

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Policy holder address (if not the same as patient's): _____

Policy holder phone number (if not the same as patient's): _____

Policy holder's Birthdate: _____ Policy holder's Soc. Sec.#: _____

If there is a balance due after insurance covers part of the visit, who will be responsible for paying the remaining balance due?

Patient: _____ Other: _____

Last First MI Last First MI

Assignment of Benefits & Release of Information

I hereby assign, transfer and set over to Provider, all of my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine benefits, including medical, surgical, psychiatric and/or substance abuse (drug or alcohol) information. This authorization shall contain valued until written notice is given by me revoking said authorization. I certify that the information given is correct. I understand that this order does not relieve me of my obligation to pay such bills if not paid by my Insurance Company; or of any balance due after payments by my Insurance Company. I agree to pay any balance due in full no later than 60 days of statement, unless other arrangements have been made in advance.

Signature: _____ Date: _____

We request that you notify our office of any changes in the following information: name, address, phone number, change in insurance, or change in marital status.

X_____ (Client initials)