CENTER FOR
Behavioral Wellness

Jeannie Dilworth, APRN | Stacey Hansen, LMFT | Tracy Lewis, LCSW | Holly Monroe, LMFT

PATIENT REGISTRATION FORM

DATE:

PERSONAL INFORMATION:

Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ F ☐ M ☐ OTHER

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Is it ok to leave a voicemail at this number?: ☐ Yes ☐ No

Cell: (_____) _____ Is it ok to leave a voicemail at this number?: ☐ Yes ☐ No

Work: (_____) _____ Is it ok to leave a voicemail at this number?: ☐ Yes ☐ No

Email: _____ Can we email you a link to our patient portal? ☐ Yes ☐ No

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Child ☐ Student

If Employed: Employers Name/Address: _____

If you are a Student, are you attending: ☐ High School ☐ College Highest grade completed: _____

Primary Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Portuguese ☐ Other: _____

Race: ☐ White ☐ Black/African-American ☐ Asian ☐ American Indian/ Alaskan Native ☐ Native Hawaiian/Other Pacific Islander

☐ Declined to Specify ☐ Other: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Preferred Pharmacy: _____ Phone Number: (_____) _____

Primary Care Physician: _____ Phone Number: (_____) _____

Emergency Contact: _____ Phone Number: (_____) _____

Referred By: _____ Phone Number: (_____) _____

Previous Psychiatric Services: _____

INSURANCE INFORMATION:

Primary Medical Insurance: _____ Policy Number: _____

Secondary Medical Insurance: _____ Policy Number: _____

☐ Copy of card given Insured Party: ☐ Self ☐ Spouse ☐ Parent

Party responsible for payment: ☐ Spouse ☐ Parent ☐ Other: _____

**Please complete this section ONLY if someone other than the client is responsible for payment:*

Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ Female ☐ Male

Address: _____ Town: _____ State: _____ Zip Code: _____

Phone Number: (_____) _____ Cell: (_____) _____ Work: (_____) _____

925 Sullivan Avenue South Windsor, CT 06074 Phone: 860.432.7771 Fax: 860.432.7774
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www.centerforbehavioralwellness.com

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ACKNOWLEDGEMENT OF POLICY STATEMENT

I, _____, have been shown the Policy Statement for this office, and have been offered a copy of such policy to keep for my records.

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

I hereby give permission for this office to leave messages on the answering service/ voicemail/ text messages or emails at:

☐ My Home (please initial) _____ ☐ My Cell (please initial) _____
☐ My Work (please initial) _____ ☐ My Email (please initial) _____

I, _____, hereby give my consent for Center for Behavioral Wellness to bill my/my child's insurance carrier for the services rendered to me/ my child/family. In addition, I agree to pay Center for Behavioral Wellness any deductibles or uncovered charges in accordance with my health care plan.

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

YOU MAY REQUEST A COPY OF OUR OFFICE POLICIES FROM OUR FRONT DESK, OR OBTAIN THEM FROM OUR WEBSITE, www.centerforbehavioralwellness.com