CENTER FOR
Behavioral Wellness

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

PATIENT REGISTRATION FORM

DATE:

PERSONAL INFORMATION:

Name: _____ Date of Birth: _____/_____/_____

Gender Identity: ☐ Identifies as male ☐ Identifies as Female ☐ Transgender Male/Female-to-Male (FTM)

☐ Transgender Female/Male-to-Female (MTF) ☐ Gender non-conforming (neither exclusively male nor female)

☐ Additional gender category/ other, please specify _____ ☐ Choose not to disclose

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

Preferred Number: (_____) _____ Is it ok to leave a voicemail and/or text? ☐ Yes ☐ No

Other Number: (_____) _____ Is it ok to leave a voicemail and/or text? ☐ Yes ☐ No

Email: _____ Can we communicate via email? ☐ 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 ☐ Graduate School Highest grade completed: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

☐ Multi-Racial ☐ White ☐ 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: (_____) _____

In case of emergency, preferred hospital/ER: _____

Referred By: _____ Phone Number: (_____) _____

Previous Psychiatric Services: _____

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INSURANCE INFORMATION:

Primary Medical Insurance: _____ Policy Number: _____

Secondary Medical Insurance: _____ Policy Number: _____

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: _____/_____/_____

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

Preferred Number: (_____) _____

BILLING CONSENT

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

I,_____, hereby give my consent for electronic billing statements by providing my email on the patient registration form and signing below.

_____

Signature of Client/Parent/Legal Representative Date Print Name

*Please Note: If no email is provided, paper billing statements will be mailed to the address on file.