Patient Registration & Contact Agreement

Initial Appt Date: ____________________

Patient Information

Last Name:____ First name: ____

Date of Birth: ______________________________________ Social Security Number: ____________________________

Marital Status:_____________________________________ Sex: _______________________________________

Address: ____

City: State: _______________________________________ Zip Code: ____

Employer: ____

Home Phone: _______________________________________ Fax: ____

Work Phone: ______________ Cell Phone: ______________ Home e-mail: ____________________________________

Other Phone: : ______________ Work e-mail: _____________________________________

Emergency Contact

Full Name: ____ Relationship: ______________________________

Home Phone: _________________ Work Phone: _________________ Cell Phone: ______________________________

E-mail Address: ____

Parent / Guardian Information - Required if the patient is under 18 years of age

Last Name:____ First name: ____

Date of Birth: ______________________________________ Social Security Number: ____________________________

Custody Status: _________________ Legal: _________________ Physical: _________________

Address: ____

City: State: _______________________________________ Zip Code: ____

Other Custodial Information: ____

Primary Insurance Information

(Innersense Behavioral Health will need a copy of both sides of the insurance card)

Insurance Company: ____

Relationship to insured: _______________________ Employer: ____

Group Number: ____ Member ID Number:______________________

Effective Dates: To: :_____________________ From: :_____________________

Insured's Information *(if not self)*

Relationship to insured: _______________________

Last Name:____ First name: ____

Date of Birth: ____ Social Security Number: ______________________________

Marital Status:____ Sex: ____

Address: ____

City: State: ____ Zip Code: ____

Secondary Insurance Information

(If Applicable, Innersense Behavioral Health will need a copy of both sides of the insurance card)

Innersense Behavioral Health Services, does not bill secondary insurance except as required by law.

Insurance Company: ____

Group Number: ____ Member ID Number:______________________

Effective Dates: To: :_____________________ From: :_____________________

Insured's Secondary Information *(if not self)*

Relationship to insured: _______________________

Last Name:____ First name: ____

Date of Birth: ____ Social Security Number: ______________________________

Marital Status:____ Sex: ____

Address: ____

City: State: ____ Zip Code: ____

I authorize Innersense Behavioral Health Services to contact me and leave messages for me using any of the above listed contact information except as individually excluded below.

____ __________________

Patient / Parent / Guardian Date