The Solution Counseling Center

Date: ____/____/_____

New Patient Registration Information

Personal Information- Please Print

Patient's Full Legal Name: _____ Social Security No.____-___-____
Last First MI

Patient's Address: _____
Street City State Zip

Patient's Phone Number(s): Home: (___) _____Work: (___) _____Ext: _____ Cell: (___) _____

Patient's Date of Birth: _____ Patient's Sex: Male: _____ Female: _____

Marital Status: ( ) Married ( ) single ( ) Divorced ( ) Separated Spouse's Name: _____

Student (if applicable): ( ) Full- Time ( ) Part-Time Name of School: _____

Employed (if applicable): ( ) Full- Time ( ) Part-Time Name of Employer: _____

How were you referred to us? ( ) Insurance ( ) Yellow Pages ( ) Family/Friend ( ) Other _____

Responsible Information- Please have Photo ID (i.e. Driver's License) available so it may be copied

Responsible's Full Legal Name: _____ Social Security No.____-___-____
Last First MI

Responsible's Address: _____
Street City State Zip

Responsible's Phone Number(s): Home: (___) _____ Work: (___) _____ Ext: _____

Responsible's Date of Birth: _____ Patient's Sex: Male: _____ Female: _____

Person Responsible for Account: ( ) Self ( ) Spouse ( ) Parent ( ) Guardian ( ) Other (please specify): _____

Insurance Information- Please provide card(s) so they may be copied

Primary Insurance Company: _____

Name of Insured: _____ Social Security No.____-___-____
Last First MI

Insured's Address: _____
Street City State Zip

Insured's Phone Number(s): Home: (___) _____ Work: (___) _____ Ext: _____

Insured's Date of Birth: _____ Insured's Sex: Male: _____ Female: _____

Patient's relationship to Insured: ( ) Self ( ) Spouse ( ) Parent ( ) Guardian ( ) Other (please specify): _____

Effective Date: _____ Policy Number: _____ Group Number_____

Secondary Insurance Company (if applicable): _____

Effective Date: _____ Policy Number: _____ Group Number_____

Message Authorization

There may be instances when your psychiatrist/office manager needs to change an appointment. To protect your confidentiality, your permission is needed to leave a message at your home with anyone other than yourself. This office has permission to leave a message regarding a scheduled appointment with: (check those that apply)

Spouse: _____ Name: _____ Phone Number (if applicable): (___) _____

Relative: _____ Name: _____ Phone Number (if applicable): (___) _____

Friend: _____ Name: _____ Phone Number (if applicable): (___) _____

Other: _____ Name: _____ Phone Number (if applicable): (___) _____

I agree to obtain insurance authorization before each visit, and to keep the doctor's office informed of any changes to my contact information or insurance status. I understand that I am financially responsible for any charges incurred by my treatment, such as unmet deductibles, co-payment or non-payment by my insurance company.

Signature of responsible party_____ Date____/__/____