PSYCHIATRIC SERVICES, S.C.

Registration Form

Provider _____ Date: _____
Patient ID #: _____

Patient Information

Name _____ DOB: _____

Social Security Number: _____ Home Phone: _____

Address: _____ Cell Phone: _____

City: _____ State: _____ Zip Code: _____ Reminder Call #: _____

Referred By: _____ Primary Care Provider: _____

Marital Status: Single Married Other Self-identified Gender: _____

Patient Email Address: _____

Employment Information

Employment Status: Part-Time Full-Time Student

Employer Name: _____ Occupation: _____

Telephone Number: _____

Responsible Party (who/where statements are to be sent) Check if Patient: _____

Name: _____ Phone Number: _____

Relationship to Patient: _____ Cell Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone Number: _____

Name of Additional Contact

Name: _____ Phone Number: _____

Relationship to Patient: _____ Cell Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Phone Number: _____

(Over)

Primary Insurance Carrier *(We will need to make a copy of your insurance card.)*

Name of Insurance Carrier: _____

Subscriber Full Name: _____ Subscriber DOB: _____

Patient's Relationship to the Subscriber: _____
(Self, Spouse, Child, Other)

Subscriber's Employer: _____

Secondary Carrier *(We will need to make a copy of your insurance card.)*

Name of Insurance Carrier: _____

Subscriber Full Name: _____ Subscriber DOB: _____

Patient's Relationship to the Subscriber: _____
(Self, Spouse, Child, Other)

Subscriber's Employer: _____

Patient's Sex (M/F) as noted on your insurance card: _____

Acknowledgement of Receipt of Notice of Privacy Procedures

This acknowledgement form is documentation that we have provided a summary of your rights as an individual receiving treatment at Psychiatric Services, S.C.: **Rights of Individuals Receiving Treatment at Psychiatric Services, S.C. (PSSC).** In addition this is to confirm that the receptionist has made a copy of our **Notice of Privacy Practices** available to you. Thank you for your cooperation and patience.

Name: _____ Date: _____

Signature of Representative: _____

Relationship to Patient:

□ Patient

□ Legally Authorized Representative:
_____ Legal Guardian _____ Parent of a Minor _____ Personal Representative of Deceased

□ Signature Declined