



Behavioral Health and Education Specialists

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New Patient Registration Form

Today's Date: _____

| | |
|------------------------------|-----------------------------|
| Patient Name: | Parent/Guardian (if minor): |
| Date of Birth: | Age: |
| Patient SSN: | Insured SSN (if different): |
| Address: | Reason For Appointment: |
| Home Phone: | Primary Care Physician: |
| Work Phone: | Physician Phone: |
| Cell Phone: | Emergency Contact: |
| How did you learn about us?: | Emergency Phone: |

Office Use Only

| | |
|-------------------------------------|--|
| Provider: | |
| <input type="checkbox"/> F. Ahmed | <input type="checkbox"/> R. Brucker |
| <input type="checkbox"/> J. Clausen | <input type="checkbox"/> C. Heath |
| <input type="checkbox"/> E. Smith | <input type="checkbox"/> J. Williamson |
| Insurance Information | Verification Of Information |
| Insurance Provider: | <input type="checkbox"/> Copy of insurance card |
| Name of Insured: | <input type="checkbox"/> Copy of driver's license |
| Identification #: | <input type="checkbox"/> Privacy form given |
| Group #: | <input type="checkbox"/> Financial policy form given |
| Information Verified By: _____ | |