Patient Registration Form

Patient's Name (First, MI, Last): ____

Preferred Name: ____

Patient's Phone Number: ____________________ Alternate Phone Number: ______________________

Can We Leave A Message with the Patient's Phone Number: Yes or No

Can We Leave A Message with the Alternate Phone Number: Yes or No

Date of Birth: __________________________ Social Security Number: ___________________________

Address: ____ Apt #: __________

City: _________________________________ State: ______________ Zip: ______________________

Email Address: ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Sex: ☐ Male ☐ Female ☐ Other

PHARMACY INFORMATION:

Pharmacy: __________________________ Pharmacy Phone Number: ___________________________

Pharmacy Address: ____

City: ____ State: _________________ Zip: ____________

INSURANCE INFORMATION:

1. Primary Insurance: ____________________________ Patient is Subscriber/Policy Holder: Yes or No
2. Secondary Insurance: __________________________ Patient is Subscriber/Policy Holder: Yes or No

PRIMARY INSURANCE HOLDER INFORMATION (if other than patient):

Policy Holder Name: ___________________________________ Relationship to patient: ________________

Date of Birth: ______________________________ Social Security Number: _________________________

EMERGENCY CONTACT INFORMATION:

(flip over)

For safety purposes, we require at least one emergency contact.

1. Name: ___________________________________ Relationship to you: ___________________

   Phone Number: _______________________

2. Name: ___________________________________ Relationship to you: ___________________

   Phone Number: ________________________

Release of Protected Health Information (PHI)

_Per HIPAA guidelines you must give permission before any information can be released to anyone other than yourself or your legal guardian.
_Please list below the name(s) and relationship of any family/friends who may have access to your PHI on record at our office. This includes prescriptions refills, appointment times, diagnosis, office chart notes, and billing information.
_If someone other than yourself contacts our office, and are not listed below, we will not release any information.

Name: _______________________________________ Relationship: __________________________

Check all items of information that may be released to above person(s):
☐ Prescriptions/Refills ☐ Appointment Time ☐ Diagnosis/Chart Notes ☐ Billing Information

Name: _______________________________________ Relationship: __________________________

Check all items of information that may be released to above person(s):
☐ Prescriptions/Refills ☐ Appointment Time ☐ Diagnosis/Chart Notes ☐ Billing Information

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES:

I hereby acknowledge that I have been offered Emerald Psychiatry & TMS Center's Notice of Privacy Practices and Office Policies.

_________ I have been offered a copy of the Notice of Privacy Practices.
INITIAL

_________ I have been offered a copy of the Office Policies.
INITIAL

____
Print Name

____ ________________
Signature Date

____ ________________
Guardian Signature (if applicable) Date

APPOINTMENT CANCELLATION NOTICE:

If it is necessary to cancel an appointment, please call our office at least 24 hours before your scheduled appointment date. If a 24-hour notice is not given, a cancellation fee will be applied to your account.