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Clinical Counselor and Mental Health Provider

Address goes here:

Brentwood, TN

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PATIENT REGISTRATION FORM

Patient's name: _____ DOB: _____

Address: _____

City: _____ ST: _____ ZIP: _____

Home #: _____ Cell (parent): _____ Work#: _____

PRIMARY SUBSCRIBER:

Name: _____ DOB: _____

Employer: _____

Employer's Address: _____

City: _____ ST: _____ ZIP: _____

Telephone Number: () _____ ext: _____

Relationship to patient: _____ Legal Guardian: yes _____ no _____

INSURANCE INFORMATION:

Type of insurance: ___ CIGNA ___ BCBS ___ AETNA ___ PHCS
___ Other (please indicate) _____

Subscriber ID# _____ Group# _____

Subscriber SS# _____ Insurance phone# (back of card) _____

For Office use:

Deductible: _____ **Co-pay:** _____ **Coverage%:** _____

Number of visits per year: _____ **used:** _____

Authorization Required: yes _____ no _____

Authorization number: _____ **Effective date:** beginning _____ ending _____