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| Guidance Foundation REGISTRATION FORM  (Please complete, print and bring to your first session) |
| Today’s Date:  | PCP:       |
| PATIENT INFORMATION |
| Patient’s last name:       | First:       | Middle:       | [ ]  Mr.[ ]  Mrs. | [ ]  Miss[ ]  Ms. | Marital status: |
|  |  |  | Single [ ]  Mar [ ]  Div [ ]  Sep [ ]  Wid [ ]  |
| Is this your legal name? | If not, what is your legal name? | (Former name): | Birth date: | Age: | Sex: |
| [ ]  Yes | [ ]  No |       |       |       |       | [ ]  M | [ ]  F |
| Street address: | Social Security no.: | Home phone no.: |
|       |       | (     )       |
| P.O. box: | City: | State: | ZIP Code: |
|       |       |       |       |
| Occupation: | Employer: | Employer phone no.: |
|       |       | (     )       |
| Chose clinic because/referred to clinic by (Please check one box): | [ ]  Dr. |       | [ ]  Insurance plan | [ ]  Hospital |
| [ ]  Family | [ ]  Friend | [ ]  Close to home/work | [ ]  Yellow Pages | [ ]  Other |       |
| Other family members seen here: |       |
|  |
| INSURANCE INFORMATION |
| (Please give your insurance card to the receptionist.) |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
|       |       |       | (     )       |
| Is this person a patient here? | [ ]  Yes | [ ]  No |  |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
|       |       |       | (     )       |
| Is this patient covered by insurance? | [ ]  Yes | [ ]  No |  |
| Please indicate primary insurance | [ ]   | [ ]   | [ ]   | [ ]   | [ ]   |
| [ ]   | [ ]   | [ ]   | [ ]  Welfare (Please provide coupon) | [ ]  Other |       |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
|       |       |       |       |       | $       |
| Patient’s relationship to subscriber: | [ ]  Self | [ ]  Spouse | [ ]  Child | [ ]  Other |       |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: |
|       |       |       |       |
| Patient’s relationship to subscriber: | [ ]  Self | [ ]  Spouse | [ ]  Child  | [ ]  Other |       |
|  |
| IN CASE OF EMERGENCY |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Work phone no.: |
|       |       | (     )       | (     )       |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Guidance Foundation, or insurance company to release any information required to process my claims. I verify that I have legal /joint custody of child and can authorize treatments. (Please provide documents if required). |
|  |  |  |  |  |
|  | Patient/Guardian signature |  | Date |  |