CREATING HEALTHY ALTERNATIVES TOGETHER CLINICAL & FORENSIC ASSESSMENT SERVICES

REGISTRATION FORM

(Please Print)

Today's date:					PCP:	
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone: ()		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:		Employer phone: ( )			
Chose clinic because/Referred to clinic by (please check one box): ❑Dr. _____ ❑ Insurance Plan ❑ Family ❑ Friend ❑ Close to home/work ❑Internet ❑ Other						

INSURANCE INFORMATION					
(Please give your insurance card to the clinician.}					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone: ()	
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone: ( )	
Primary Insurance:					
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					

IN CASE OF EMERGENCY			
Name of friend/ relative/ spouse:	Relationship to patient:	Home phone: ( )	Work phone: ( )

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 Creating Healthy Alternatives Together Clinical & Forensic Assessment Services or insurance company to release any information required toprocess my claims.

_____ _____

Patient/Guardian signature *Date*