## Peace of Mind Mental Health Services, LLC

# REGISTRATION FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |
| --- | --- |
| Today’s Date:  |  |

PATIENT INFORMATION

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patients First Name: | Last: | Middle:  |  | Marital status: Circle oneSingle / Mar / Div / Sep / Wid |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is this your legal name? | If not, what is your legal name? | Former name: | Birth date: | Age: | Sex: |
|  |  |  |  |  |  |

Address: City: State: Zip code:

|  |  |  |
| --- | --- | --- |
| Social Security no.: | Home phone no.: | Cell phone no.: |
|  |  |  |
| Occupation: | Employer: | Employer phone no.: |
|  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| I was referred by (please check one box): | ❑ Dr. | ❑ Hospital | ❑ Insurance Plan | ❑ Insurance co |  |
| ❑ Family | ❑ Friend | ❑ Close to home/work | ❑ Other |  |  |
| **Child or Adolescent** |
| Lives with: ❑ Both parents ❑ One parent and step-parent ❑ One parent ❑ Relatives ❑ Foster Care ❑ Other |
| Attending School? Y N | Name of School: |  | Grade: \_\_\_\_\_\_\_ Spec Ed? Y N |
| **\*Custodial Parents or Legal Guardian/Responsible Party** |
| Last Name | First name | Middle Initial | Phone: |
| Relationship to Child: | Lives with the child: ❑ Yes ❑ No |
| **Other adult with custodial rights** |
| Last Name | First name | Middle Initial  | Phone: |
| Relationship to Child: | Lives with the child: ❑ Yes ❑ No |

Insurance Information on Back SideINSURANCE 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? |  | Is this patient covered by insurance? |  |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
|  |  |  |  |

Please indicate primary insurance: | Other:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: | Co-payment: |
|  |  |  |  |  |  |

Patient’s relationship to subscriber: | Other:

|  |  |  |  |
| --- | --- | --- | --- |
| Name of secondary insurance (if applicable): | Subscriber’s name: | Group no.: | Policy no.: |
|  |  |  |  |

Patient’s relationship to subscriber: | Other:  |