## 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 one  Single / 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 Side 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? |  | 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: |