ABBC NPT Reg Form

Patient Registration Form

Please complete all the information below. Do not leave any questions blank. Thank You!

1. Please complete this form and once submitted we will contact you to schedule an appointment.

First Name: _____

Middle Initial: _____

Last Name: _____

Date of Birth: _____

Gender
○ Female ○ Male

Social Security #: _____

Street Address: _____

Apt./Unit #: _____

City: _____

State: _____

Zip Code: _____

Home Phone: _____

Cell Phone: _____

Email: _____

Preferred Contact Method:
○ Mobile ○ Home Phone
○ Email

Race:
☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan
☐ Native Hawaiian/Pacific Islander
☐ Other:

How did you learn about this office? _____

Who referred you? _____

Pharmacy Name _____

Pharmacy Phone# _____

Pharmacy Address _____

Pharmacy City _____

Pharmacy State _____

Pharmacy Zip Code _____

2. Please provide reason that you are requesting to be seen. (Ex. Depression, Anxiety, ADHD)

_____

_____

_____

_____

3. Emergency Contact Information.

Emergency Contact Name: _____

Relationship _____

Phone # _____

4. For Minor Patients Only:

Mother Name

Mother Phone#

Street Address

City

State

Zip Code

Father Name

Father Phone#

Street Address

City

State

Zip Code

5. Do you have medical insurance?

- Yes
- No

6. Primary Insurance

Primary Insurance Company

Insurance Phone #

Insurance Address

Member ID/Policy #

Group #

Client Relationship to Insured

Self Spouse Child Other

Policy Holder Name

Policy Holder Phone #

Policy Holder Date of Birth

Policy Holder Gender

Policy Holder Street Address

Policy Holder City

Policy Holder State

Policy Holder Zip Code

Do you have Secondary Insurance

Yes No

7. Secondary Insurance

Secondary Insurance Company

Insurance Phone #

Insurance Address

Member ID/Policy #

Group #

Client Relationship to Insured

○ Self ○ Spouse ○ Child ○ Other

Policy Holder Name

Policy Holder Phone #

Policy Holder Date of Birth

Policy Holder Gender

○ ○

Policy Holder Street Address

Policy Holder City

Policy Holder State

Policy Holder Zip Code

8. If you have insurance, please upload a copy of your insurance card here. Please include front and back of card.

9. Medications you are currently taking

10. Medications you have previously tried