PATIENT REGISTRATION FORM

Patient Information:

Last Name: _____ First Name: _____ Middle: _____ Date of Birth:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ SSN#_____ Sex: _____

Email Address: _____
(Needed to access patient portal and receive reminders for our office)

Insurance Policy Information: (Policy Subscriber Information – If not patient)

Insurance Company: _____ Subscriber Name: _____

DOB: _____ Relationship to Patient: _____ Phone #: _____

Emergency Contact:

Name: _____ Phone #: _____ Relationship: _____

Primary Physician Information:

Name: _____ City: _____ State: _____ Phone #: _____

Referring Physician Information:

Name: _____ City: _____ State: _____ Phone #: _____

For Minors Only:

Dad Information:

Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____

Mom Information:

Name: _____
Address: _____
City/State/Zip: _____
Phone #: _____

Pharmacy:

Name: _____ Address: _____ City/State: _____

(OVER)

Acknowledgement of Receipt of Notice of Privacy Practice
This will be retained for your medical records.

By my signature below, I _____, acknowledge that I received a copy of the notice of Practice of Privacy Policy for Optimum Mental Healthcare Professionals.

Signature: _____ Date: _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Patient's Name: _____

Patient's DOB: _____

Personal Representative's Name: _____

Relationship to Patient: _____

Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Practice of Privacy policy, but acknowledgment could not be obtained because:

_____ Individual refused to sign.

_____ Communication barriers prohibited obtaining acknowledgement.

_____ An emergency situation prevented obtaining acknowledgement.

_____ Other (Please specify) _____

Employee Name: _____ Date: _____

V3 12.6.23