

**REGISTRATION INFORMATION FORM**

**PLEASE ANSWER ALL INFORMATION REQUESTED. DO NOT LEAVE ANY BLANKS AND PRINT CLEARLY.**

**\*\*\*PATIENT INFORMATION\*\*\***

Patient: \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Gender: ( )M ( )F Age: \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ ( )Single ( )Married ( )Other  
Address: \_\_\_\_\_ City, State/Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ E-mail address \_\_\_\_\_  
Patient employer/phone #: \_\_\_\_\_  
PCP Primary Care Physician: \_\_\_\_\_

**\*\*\*PARENT OR GUARDIAN INFORMATION\*\*\* (necessary if the patient is a minor)**

Parent/Guardian name: \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to patient if not parent: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**\*\*\*INSURANCE INFORMATION\*\*\* (MUST BE COMPLETED)**

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

**SUBSCRIBER INFORMATION:** (Insured's information)

Subscriber: \_\_\_\_\_ Relationship to pt.: self/dad/mom/spouse/guardian/other \_\_\_\_\_  
Subscriber SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber date of birth: \_\_\_\_\_ Employer \_\_\_\_\_  
Address: \_\_\_\_\_ City, State/Zip: \_\_\_\_\_

**\*\*\*EMPLOYEE ASSISTANCE PROGRAM INFORMATION \*\*\* (if applicable)**

EAP Company: \_\_\_\_\_ Employee: \_\_\_\_\_  
SSN \_\_\_\_\_ Employer \_\_\_\_\_ DOB \_\_\_\_\_

**REGISTRATION INFORMATION FORM**

Patient Name: \_\_\_\_\_

ID #: \_\_\_\_\_

**PLEASE DO NOT LEAVE ANY BLANKS. PLEASE WRITE "NONE" OR "N/A" IF A SECTION DOES NOT APPLY**

Have any of your relatives had?

- Alcoholism                      Drug Dependency  
Cardiac Problems              Mental/Emotional Problems  
Diabetes                              High Blood Pressure

Indicate the amounts of the following substances

you use on a daily basis:

Alcohol \_\_\_\_\_ Coffee \_\_\_\_\_ Tea \_\_\_\_\_  
 Drugs \_\_\_\_\_ Tobacco \_\_\_\_\_

**MEDICAL HISTORY:**

Current: \_\_\_\_\_

\_\_\_\_\_

Past: \_\_\_\_\_

\_\_\_\_\_

Food & Medication allergies: \_\_\_\_\_

Date of last physical exam? \_\_\_\_\_

**Current & Past Medications for Medical and Psychiatric Conditions**

Condition	Medication	Dosage (mg)	Frequency	Date started	Effective?

**Previous Mental Health and Substance Abuse Treatment**

Date of Service	Provider Name	Level of Care	Duration	Nature of Problem	Helpful?

**I understand my signature gives consent for treatment:**

\_\_\_\_\_  
 Patient signature (14 and older)

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Parent/guardian signature (if under 18)

\_\_\_\_\_  
 Date