Quarternote Counseling LLC DATE_____

PATIENT REGISTRATION

PERSONAL INFORMATION

NAME_____

Last Middle (Maiden) First

STREET ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE _____ WORK_____ CELL_____

E-MAIL_____

GENDER_____SS#_____DATE OF BIRTH_____

MARITAL STATUS_____ OCCUPATION_____

EMPLOYER_____

SPOUSE/SIGNIFICANT OTHER:_____

EMERGENCY CONTACT_____RELATIONSHIP_____

EMERGENCY CONTACT PHONE NUMBER_____

RESPONSIBLE PARTY (IF DIFFERENT THAN PATIENT)

NAME_____

Last Middle First

RELATIONSHIP TO PATIENT_____

STREET ADDRESS_____

CITY_____STATE_____ ZIP CODE_____

SS#_____ EMAIL_____

EMPLOYER_____ OCCUPATION_____

HOME PHONE_____ WORK_____CELL_____

Meaningful Use Data:

PREFERRED LANGIAGE:_____

We want to make sure that all our patients get the best care possible. We would like you to tell us your racial and ethnic background so that we can periodically review our patient data and make sure that everyone is receiving the highest quality of care."

Do you consider yourself Hispanic/Latino? Yes No Declined

Which category best describes your race? (Circle any you feel apply)

White American Indian/Alaska Native Asian Black or African American

Native Hawaiian/Other Pacific Islander Decline

INSURANCE INFORMATION

PRIMARY _____ SECONDARY_____

NAME OF INSURED_____ NAME OF INSURED_____

RELATIONSHIP TO PATIENT_____ RELATIONSHIP TO PATIENT_____

INSURED'S DATE OF BIRTH_____ INSURED'S DATE OF BIRTH_____

SS#_____ SS#_____

SUBSCRIBER'S MEMBER #_____ SUBSCRIBER'S MEMBER #_____

GROUP #_____ GROUP #_____

ADDRESS_____ ADDRESS_____

_____ _____

INS. PHONE_____ INS. PHONE_____

IN CASE OF EMERGENCY:

Contact:_____Relationship _____

Home phone: (_____)_____Work phone: (_____)_____

REFERRAL INFORMATION

Reason for referral:_____

Referred to clinic by (Please check one box):†Dr._____

†Insurance plan†Hospital†Family†Friend† Close to home/work/school†Self

†Yellow Pages†Other_____

I authorize you to contact my referring physician to notify him/her that I have arrived to initial session. †

Yes †No

CONTACT PERMISSION

Best contact number to reach you at: _____Home) _____(Cell) _____(work)

(other):_____

May we leave message on voicemail? _____(yes) _____(no)

May we text you? _____(yes) _____ (no)

Do we have your permission to leave a scheduling message with anyone who might answer the phone number you have indicated? _____(yes) _____(no)

Patient or Legal Guardian Signature_____Date_____

Printed Name:_____