Malachite Institute for Behavioral Health, LLC
6931 Arlington Road
Suite 530
Bethesda, MD 20814

PATIENT REGISTRATION FORM

Today's Date:	**Primary doctor:** **Phone:** **Psychiatrist:** **Phone:**				
PATIENT INFORMATION					
Client's last name: **First:**		**Middle:** **Title:**		**Relationship status:**	
Is this your legal name? ○ Yes ○ No	**If not, what is your legal name?**	**Former name:**	**Birth date:**	**Age:**	**Gender:**
Street Address:		**City:**	**State:**	**Zip:**	
Cell phone no:	**Home phone no:**		**Email:**		
Occupation:	**Employer:**		**Employer phone no.:**		
How did you hear about us?		**Preferred method(s) of contact: ___ Email ___ Cell Phone ___ Work Phone** **May we leave a voice message? _____YES _____NO** **May we send a text message? _____YES _____NO** **May we send an email? _____ _____YES _____NO __**			
INSURANCE INFORMATION- PLEASE PROVIDE COPY OF CARD (FRONT & BACK)					
Person responsible for bill if other than patient: Bills will be mailed to responsible party.	**Birth date:**	**Address (if different):**	**Home phone no.:**		
Please indicate primary insurance:					
Subscriber's name:	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment:**	
Patient's relationship to subscriber: ___Self ___Spouse ___Child ___Other Dependent: _____					
Name of secondary insurance (if applicable):					
Subscriber's name:	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment:**	
Patient's relationship to subscriber: ___Self ___Spouse ___Child ___Other Dependent: _____					
IN CASE OF EMERGENCY- PLEASE LIST TWO CONTACTS					
Name of local friend or relative:	**Relationship:**	**Phone #(s):**			
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The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Layla Kassem and Malachite Institute for Behavioral Health or insurance company to release any information required to process my claims.

Client/Parent/Guardian (if minor) signature

Date