PATIENT REGISTRATION FORM

Today's Date:	Primary doctor: Phone: Psychiatrist: Phone:

PATIENT INFORMATION

Patient's last name: First:	Middle: Title:	Marital status: __Single ___ Married ___ Divorced __Widowed

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ◯ M ◯ F

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

INSURANCE INFORMATION- PLEASE PROVIDE COPY OF CARD (FRONT & BACK)

Person responsible for bill if other than patient:	Birth date:	Address (if different):	Home phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	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:	Subscriber's S.S. no.:	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.

Patient/Guardian signature Date