REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Last name:	First name:	Middle initial:	Nickname:

E-mail address:	Date of birth:	Marital status:	Age:	Gender:

Complete Address (Include City & ZiPCode):

Home phone #:	Cell phone #:	Work phone #:

Where do you preferred to be contacted?

Occupation:	Employer:

How did you hear about our office?

INSURANCE INFORMATION

(Please give your insurance card to the front desk staff.)

Person responsible for bill:	Birth date of responsible party:	Address (if different):	Best contact #:

Please indicate primary insurance:

Subscriber's name:		Birth date:	ID #:	Group #:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Home phone #:	Cell phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Oak Hill Psychological Services, PLLC. I understand that I am financially responsible for any balance. I also authorize Oak Hill Psychological Services, PLLC, or -my insurance company to release any information required to process my claims.

Patient/Parent or Guardian signature   Date