BIO-BEHAVIORAL MEDICAL CLINICS, INC.

Patient Registration

Are these services Court ordered? ☐ **YES** ☐ **NO**

PATIENT INFORMATION

☐ New Patient ☐ Information Update

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Other

Address: _____ City: _____ State: _____ Zip: _____

Primary Contact Phone: _____ Message ok? ☐ Y ☐ N Secondary: _____

Race: ☐ White ☐ Black ☐ Native Hawaiian ☐ American Indian ☐ Other

Ethnicity: ☐ Latino/Hispanic ☐ Other

Employer: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Referring Physician: _____ Driver's License #: _____

SPOUSE / PARTNER INFORMATION (If relevant)

Spouse/Partner's Name: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

FINANCIAL RESPONSIBILITY

Responsible Party: _____ Social Security #: _____

Date of Birth: _____ Driver License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (Must complete ALL the information below in order to bill your Insurance)

Primary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

SIGNATURE and DATE

_____ _____

Patient or Responsible Party Date

Revised: September 2015