OLD GEORGETOWN MENTAL HEALTH ASSOCIATION, L.L.C.

PATIENT REGISTRATION INFORMATION

Please Print Clearly

PLEASE PROVIDE A COPY OF YOUR CURRENT INSURANCE CARD. NOTE: WHEN INSURANCE IS UPDATED PLEASE PROVIDE A COPY TO THE OFFICE TO ENSURE PRESCRIPTIONS CAN BE FILLED.

Please circle: NEW PATIENT / RETURNING PATIENT

DATE: _____ Physician to be seen: _____ ACCT #:_____

Referred by:_____ Signature to authorize Dr. to contact referral:_____

PERSONAL INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ Unit#: ____ City: _____ State ____ Zip Code _____

DOB: ___/___/_____ SSN: _____-____-_____ Sex ___ Marital Status: _____

Home Phone: _____ Cell: _____ Email Address: _____

Preferred Phone Number:_____

EMPLOYMENT

Employer/School: _____ Address _____

Phone Number: (____)_____

MEDICAL

Primary Care Physician: _____ _____ Phone: (____) _____Fax: (____) _____

Therapist: _____ Phone: (____) _____ Fax: (____) _____

Pharmacy: _____ Phone: (____) _____ Fax: (____) _____

Mail Order Pharmacy Name: _____ Email: _____

Permission to contact Primary Care and other Therapists? Please Initial _____

INSURANCE (for Prior Authorization)

Primary Insurance*: _____ Insurance ID#: _____

Secondary Insurance:_____ Insurance ID #: _____

IN CASE OF AN EMERGENCY

NAME: _____ Relationship: _____

Home Phone: _____ Work: _____ Cell: _____