

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: _____
Cell Phone: _____ Work Phone: _____ Home Phone: _____
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 for us to bill you 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