North Houston Psychiatry, PLLC

REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital	
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other		
Other family members seen here:						

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):		Home phone no.: ( )	
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Employer phone no.: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No					
Name of primary insurance:					
Subscriber's name:	Subscriber's S.S. no.:	Subscriber's Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 North Houston Psychiatry,PLLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*