Riverbend
PSYCHIATRY

NEW PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS

Name (First, MI, Last) _____ Date_____

Preferred name_____ Birthdate_____ Social Security #_____

Address_____ City_____ ST_____ Zip_____

Home phone _____ Cell phone_____ Work phone_____

Emergency Contact _____relationship_____phone_____

E-mail_____

Marital status (*circle one*): **married single divorced separated widowed partner**

Race: **White Black/African American Hispanic Asian Other:_____**

Preferred Language _____ Ethnicity_____

Preferred Pharmacy_____ Phone_____

Primary Care Provider _____ Phone_____

Referred by_____

INSURANCE INFORMATION

Primary Insurance company (as it appears on card) _____

Subscriber _____Patient relationship to subscriber_____

Member ID#_____Group#_____

Secondary Insurance company (as it appears on card) _____

Subscriber _____ Patient relationship to subscriber_____

Member ID#_____Group#_____

Mental Health Insurance company (as it appears on card) _____

Subscriber _____ Patient relationship to subscriber_____

Member ID#_____Group#_____