Date: _____/_______/_______ Account: ___________

Solutions Behavioral Healthcare Professionals

PATIENT REGISTRATION

Gender: □ Male □ Female Date of Birth: __________ Referral Source: ______________________

Last Name: ___________________________ First Name: _____________________ Middle Name: ____________

Street Address: ____

City: ______________________________ State: ______________________ Zip Code: ______________________

Primary Phone: (______) ________________ □ Cell □ Home □ Work Permission to leave message? □ Yes □ No

Whose phone number is this? □ Client □ Other: _______________________________

Secondary Phone: (______) ________________ □ Cell □ Home □ Work Permission to leave message? □ Yes □ No

Whose phone number is this? □ Client □ Other: _______________________________

Emergency Contact Name: _______________________________________ Phone Number: __________________

Relationship to Client: □ Spouse □ Parent □ Other Guardian □ Other: __________________________

Appointment Reminders Requested: □ Text message □ Phone call □ None

Phone number for reminder: □ Primary □ Secondary □ Other: _________________________________

Cell Phone Provider: □ Verizon □ Sprint □ AT&T □ T-Mobile □ Other: __________________________

Register for online Patient Portal: □ No □ Yes - e-mail address: ____

REQUIRED FOR CLIENTS UNDER 18

Father's Full Name: ______________________________ Mother's Full Name: ______________________________

Father's Address: ________________________________ Mother's Address: ________________________________

City: ______________ State: ______ Zip Code: ________ City: ______________ State: _______ Zip Code: ________

Father's Phone: _________________________________ Mother's Phone: _________________________________

CUSTODY OF CLIENT

Legal documentation or written permission from both parents allowing treatment may be necessary

Legal Custody

- ☐ Both Biological Parents
- ☐ One Biological Parent: Mother
- ☐ One Biological Parent: Father
- ☐ Adoptive Parent(s)
- ☐ Agency: ______________
- ☐ Other: ______________

Physical Custody

- ☐ Both Biological Parents
- ☐ One Biological Parent: Mother
- ☐ One Biological Parent: Father
- ☐ Adoptive Parent(s)
- ☐ Agency: ______________
- ☐ Other: ______________

GUARDIANSHIP INFORMATION

Does client have a legal guardian? □ No □ Yes - indicate below if not parents listed above for minor

Last Name: ___________________________ First Name: __________________ Middle Name: _______________

Street Address: ____

City: ______________________________________ State: ________________ Zip Code: ______________________

Preferred Phone: (______) ________________ □ Cell □ Home □ Work Permission to leave message? □ Yes □ No

Over ➡

BILLING INFORMATION

RESPONSIBLE PARTY (Please complete if different from client or if client is a minor)

Last Name: ___________________________ First Name: _____________________ Middle Name: ____________

Street Address: ____

City: ______________________________ State: ______________________ Zip Code: ______________________

Primary Phone: (______)_______________ □ Cell □ Home □ Work Permission to leave message? □ Yes □ No

Secondary Phone: (______)______________ □ Cell □ Home □ Work Permission to leave message? □ Yes □ No

Date of Birth: ________________ Social Security Number: _______________________

Relationship to Client: □ Spouse □ Parent □ Guardian □ Other: _________________

THE INFORMATION IN THIS SECTION IS NECESSARY FOR REQUIRED STATE PURPOSES

Social Security Number of Client: ___________________

HEALTHCARE DIRECTIVE

Have any end-of-life decisions or a "living will" been legally arranged?

□ Yes □ No, and I am not interested in further information □ No, but I would like more information

MARITAL STATUS

□ N/A – Child □ Single □ Married □ Legally married, but separated □ Legally divorced □ Widowed

EMPLOYMENT STATUS

□ N/A – Child □ Student □ Full Time □ Part Time □ Retired □ Unemployed □ Disabled

USA VETERAN STATUS

□ N/A – Child □ Not a Veteran □ Vietnam Veteran □ Other Veteran

ETHINICITY

□ Hispanic/Latino □ Not Hispanic or Latino □ Unknown

RACE

□ White/Caucasian □ African American/Black □ Native Hawaiian/Pacific Islander □ Asian □ American Indian/Alaska Native □ Unknown

TRIBAL ENROLLMENT: □ N/A □ Yes: ________________________ **RESERVATION OF RESIDENCE:** □ N/A □ Yes: ________________________

COUNTRY OF ORIGIN (IF NOT USA): _________________________ **PREFERRED LANGUAGE (IF NOT ENGLISH):** _________________________

INSURANCE INFORMATION

Primary Insurance: ____

Policy Holder: ____ Policy Holder DOB: _________________

FULL NAME AS IT APPEARS ON INSURANCE CARD

Policy ID Number: ____ Group #: ________________________

Secondary Insurance: ____

Policy Holder: ____ Policy Holder DOB: _________________

FULL NAME AS IT APPEARS ON INSURANCE CARD

Policy ID Number: ____ Group #: ________________________