



Behavioral Health and Education Specialists

Plainfield New Patient Registration Form

Today's Date: ____ / ____ / ____

Patient Name:	Parent/Guardian (if minor):
Patient Date of Birth:	Name of Insured:
Patient Social Security Number:	Insured Social Security Number:
E-mail Address:	Insured Date of Birth:
Name of Financially Responsible Person:	Insured's Relationship to Patient:
Financially Responsible Person's Date of Birth:	Financially Responsible Person's Social Security Number:
Patient Address:	Reason For Appointment:
Any Known Allergies:	Current Medications:
Home Phone:	Primary Care Physician:
Work Phone:	Physician Phone:
Cell Phone:	Emergency Contact:
How did you learn about us:	Emergency Phone:

Office Use Only

Provider:	
<input type="checkbox"/> F. Ahmed	<input type="checkbox"/> M. Azhar
<input type="checkbox"/> J. Garlick	<input type="checkbox"/> G. Ginski
<input type="checkbox"/> P. Murphy	<input type="checkbox"/> S. Pyatetsky
<input type="checkbox"/> R. Brucker	<input type="checkbox"/> E. Smith
<input type="checkbox"/> J. Clausen	<input type="checkbox"/> C. Westrick
<input type="checkbox"/> K. Costello	<input type="checkbox"/> W. Lin
Insurance Information:	
Primary Insurance Provider: Aetna BCBS Cigna Medicare Multiplan Self Pay UBH/UNHC	Secondary Insurance Provider: Aetna BCBS Cigna Medicare Multiplan UBH/UNHC
Name of Insured:	Name of Insured:
Identification Number:	Identification Number:
Group Number:	Group Number:
Verify: <input type="checkbox"/> Copy of Insurance Card <input type="checkbox"/> Copy of Driver's License <input type="checkbox"/> Privacy Form Given <input type="checkbox"/> Financial Policy Form Given Verified By: ____	