Behavioral Health and Education Specialists

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:

☐ F. Ahmed	☐ M. Azhar	☐ R. Brucker	☐ J. Clausen	☐ K. Costello
☐ J. Garlick	☐ W. Lin	☐ P. Murphy	☐ E. Smith	☐ C. Westrick

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: ☐ Copy of Insurance Card ☐ Copy of Driver's License ☐ Privacy Form Given ☐ Financial Policy Form Given Verified By:____