

S | P | A
SOUTHAMPTON
psychiatricassociates

REGISTRATION FORM

Date ____/____/____

Name _____ Sex _____ DOB ____/____/____
Last First MI

Address _____

City _____ State _____ Zip _____

Phone _____ Cell Phone _____

Marital Status Minor Single Married Divorced Widowed Separated

Employment Full Time Part time Minor Unemployed Disability

Employer Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

If Student Full Time Part Time School/College _____

School Address _____

City _____ State _____ Zip _____

Referred by _____ MD Ph.D Therapist

Address _____

City _____ State _____ Zip _____

Phone _____

Family Dr/Pediatrician _____ Phone _____
Address _____
City _____ State _____ Zip _____

Responsible Party Name _____ DOB ____ / ____ / ____
Relationship to Patient _____ Social Security # _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Employer _____ Address _____

Emergency Contact _____ Relationship _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell Phone _____

Primary Insurance Information – must be complete in order to bill insurance

Name of Insured _____ DOB ____ / ____ / ____ Soc Sec # _____
Insurance Company Name _____ Telephone _____
ID # _____ Group _____
Employer _____ Relationship to Patient _____

Secondary Insurance Info, if applicable – must be complete in order to bill insurance

Name of Insured _____ DOB ____ / ____ / ____ Soc Sec # _____
Insurance Company Name _____ Telephone _____
ID # _____ Group _____
Employer _____ Relationship to Patient _____

Prescription Drug Coverage – must be complete in order to obtain prior authorization or pre certification

Company Name _____ ID # _____

Phone _____ Fax _____

If Patient is under 18, please complete the following if applicable

Noncustodial parent information

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Ph _____ Cell Ph _____

The following statements MUST be signed by ALL patients, age 14 and over. If patient is under 14, parent must sign

My signature below indicates that I have read and understood the office policies of Southampton Psychiatric Associates. I also understand that failure to pay for any services rendered not covered by my insurance can result in legal action.

Signature _____ Relationship to patient _____ Date ____/____/____

I give my consent to Southampton Psychiatric Associates to evaluate and/or treat myself or my child under 14 years of age.

Signature _____ Relationship to patient _____ Date ____/____/____

The following statements must be signed by patients aged 14 and over, in order for Southampton Psychiatric Associates to bill any insurance. If patient is under 14, parent must sign

Release of Information I authorize the release of any medical or other information necessary to process any insurance claims. I also request payment of benefits either to myself or to the party who accepts assignment.

Signature _____ Relationship to patient _____ Date ____/____/____

I authorize payment of medical benefits to the undersigned physician or supplier of services described.

Signature _____ Relationship to patient _____ Date ____/____/____

FOR PERSONAL CHOICE PATIENTS ONLY (please indicate one)

I do / do not

wish for my primary care physician to be informed periodically of my treatment at Southampton Psychiatric Associates.

Signature _____ Relationship to patient _____ Date ____/____/____

If your primary care physician is to be informed of your treatment, the following information must be completed

Primary Care Physician Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

**Receipt of Notice of Privacy Practices
Written Acknowledgement Form**

I, _____,
have received a copy of Southampton Psychiatric Associates Notice of Privacy Practices.

Signature of Patient

Date

If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name _____

Relationship to Client: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- An emergency situation prevented us from obtaining the acknowledgement
- Communication barriers prohibited obtaining the acknowledgement
- Other (please specify):

This form will be retained in your medical record

IMMUNIZATION HISTORY	YEAR	OTHER VACINES	YEAR
Last Tetanus Shot?	_____	Lyme Vaccine?	_____
Pneumovax Shot?	_____	Hepatitis A Vaccine?	_____
Flu Shot?	_____		
Hepatitis B Vaccine?	_____		

SCREENING TESTS (LAST ONE)	YEAR		YEAR
Mammogram?	_____	Breast exam?	_____
Pap Smear?	_____	Cholesterol Check?	_____
Stool check for blood?	_____	Prostate Exam?	_____

FAMILY HISTORY ILLNESS	GRAND FATHER	GRAND MOTHER	FATHER	MOTHER	BROTHER	SISTER	CHILD	AGES WHEN DIAGNOSED
	Cancer (type)							
Hypertension								
Diabetes								
Stroke								
Mental Disease (anxiety, depression)								
Drug or Alcohol addiction								
Glaucoma								
Bleeding diseases								
Other:								

PREVENTION			
Do you wear seat belts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women: Do you perform self breast exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear a bike helmet?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Men: Do you perform self testicular exams?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you smoke? Amount: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you following a speci c diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink co ee? Amount: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	If so, type of diet: _____	
Do you drink tea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you ever feel afraid of your partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there a gun in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a living will?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use drugs? Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a donor card?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever engaged in any activity which would put you at risk of AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever worked with chemicals, paints, asbestos or other hazardous material?	<input type="checkbox"/> Yes <input type="checkbox"/> No		