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 Pyschiatric Associates to evaluate and/or treat myself.

Signature _____Date _____/_____/____

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

Signature _____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 _____