

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.

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 \_\_\_\_\_