New Patient Registration Information

PATIENT INFORMATION					
Last Name	First Name	Middle Name			
Social Security Number	Gender	Date of Birth	Name you preferred to be called/Alias		
Street Address	City	State	Zip		
Home Phone	Work Phone	Cell Phone	Email		
Marital Status	Previous/Maiden Name	Written Language	Spoken Language		
Interpreter Needed?	VA Status ☐ Yes ☐ No	Race/Ethnicity (optional)			
Primary Care Provider (Name and Phone)	Employer Name				
Emergency Contact	Relation	Home Phone	Work Phone	Cell Phone	
Legal Next of Kin *(if different)*	Relation	Home Phone	Work Phone	Cell Phone	

RESPONSIBLE PARTY INFORMATION (if different from patient)				
Last Name	First Name	MI	Alias or Maiden Name	
Social Security Number	Gender	Date of Birth	Relationship to the Patient	
Street Address (if different from above)	City	State	Zip	
Home Phone	Work Phone	Cell Phone		
Employer Name	Occupation	Status		

PRIMARY INSURANCE				
Insurance Company Name	Group Number	Subscriber ID Number	Copay	
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient	
Subscriber's Employer Name	Subscriber's Home Phone	Subscriber's Work Phone		

SECONDARY INSURANCE				
Insurance Company Name	Group Number	Subscriber ID Number	Copay	
Subscriber's Name	Social Security Number	Date of Birth	Relationship to Patient	
Subscriber's Employer Name	Subscriber's Home Phone	Subscriber's Work Phone		

ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to The Charis Clinic PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I authorize Charis Clinic PLLC to release the necessary information for use by insurance company(ies) for processing claims for treatment and/or for requesting the authorization of additional sessions, including the release of personal health information, diagnosis, and clinical information.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Note for clients between the ages of 13 and 26: If a parent(s) is responsible for the billing aspects of treatment, please make sure the parent(s) provide the above information and signatures.

Is This Visit Related to a Work Injury or Motor Vehicle Accident? ***If "yes", please complete the below.***

☐ **Work Related Injury**

Worker's Comp (Includes Labor & Industries)

Employer:		Date of Injury:
Body Part Injured and Description:		Claim Number:
Adjuster/Claims Manager Name:		Phone Number:
Insurance Name:	Address:	
City:	State/Zip:	L & I Claim Completed? Yes No

☐ **Motor Vehicle Accident (PIP) Insurance**

Personal Injury Protection Insurance (Third Party/Motor Vehicle)

Date of Injury:	Body Part Injured and Description:
Claim Number:	Adjuster/Claims Manager Name:
Adjuster Phone Number:	Insurance Name:
Insurance Address:	
City:	State/Zip: