LEAD Behavioral Health

Patient Registration

Are these services Court ordered? ☐ YES ☐ NO

PATIENT INFORMATION ☐ New Patient ☐ Information Update

Patient Name: _____ Social Security #: _____
Date of Birth: _____ Sex: ☐ M ☐ F Marital Status: ☐ Married ☐ Single ☐ Other
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Work Phone: _____ Home Phone: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact: _____ Relationship: _____ Phone: _____
Referring Physician: _____ Driver's License #: _____

SPOUSE / PARTNER INFORMATION (If relevant)

Spouse/Partner's Name: _____
Date of Birth: _____ Sex: ☐ M ☐ F
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____

FINANCIAL RESPONSIBILITY

Responsible Party: _____ Social Security #: _____
Date of Birth: _____ Driver License #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Employer: _____ Occupation: _____
Work Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION (Must complete ALL the information below in order to bill you insurance)

Primary Insurance: _____ Subscriber Name: _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Address: _____ City: _____ State: _____ Zip: _____
Secondary Insurance: _____ Subscriber Name: _____
Subscriber Date of Birth: _____ Subscriber ID #: _____ Group #: _____
Address: _____ City: _____ State: _____ Zip: _____

SIGNATURE and DATE

_____ _____
Patient or Responsible Party Date

Revised: February 2011