ELLINGTON BEHAVIORAL HEALTH

16 Main Street
Ellington, CT 06029
(T) 860.871.5402
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REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Preferred Phone: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

If you are a student, are you attending: ❑ High School ❑ College Highest grade completed:_____

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr._____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Primary Language: ❑ English ❑ Spanish ❑ Other:_____

Race: ❑ White ❑ Black/African American ❑ Asian ❑ Declined to Specify ❑ Other:_____

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to Specify

Preferred Pharmacy: Phone Number:

Primary Care Physician: Phone Number:

Emergency Contact: Phone Number:

Previous Psychiatric Services:

HEALTH HISTORY

Please list any/all allergies or adverse reactions to medication or substances: ❑ Check if none

Health Habits: Please choose which substances you use and describe how much you use and/or how often habit is engaged in.
❑ Caffeine_____ ❑ Alcohol_____ ❑ Drugs_____ ❑ Tobacco_____ ❑ Other_____ ❑ None

Have you had any serious illnesses, operations, or been hospitalized in the past 5 years? If yes, please describe below. ❑ No

CURRENT MEDICATIONS

Name of Medication:
Dose or Strength of Medication:
Directions:
Prescribing Physician:

Name of Medication:
Dose or Strength of Medication:
Directions:
Prescribing Physician:

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Dose or Strength of Medication:
Directions:
Prescribing Physician:

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Dose or Strength of Medication:
Directions:
Prescribing Physician:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

ACKNOWLEDGEMENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*