Lifespan Behavioral Health Services

Taking Steps Together

Lifespan Behavioral Health Services PC
PATIENT REGISTRATION FORM

Full Name: _____
(First) (Middle) (Last)
Date of Birth:____/_____/____
Gender: _____**Marital Status (circle):** Single Married Divorced Widowed
Address: _____**City:** _____**State:** _____**Zip Code:** _____
***Preferred Phone Number:** ☐Home _____☐Cell _____
*Email_____

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown/Declined

Race: ☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐ Native Hawaiian/Pacific Island
☐White ☐Other ☐ Unknown/Declined

Preferred Language: ☐English ☐Spanish ☐Chinese (Cantonese) ☐Chinese (Mandarin) ☐French ☐German
☐Italian ☐Japanese ☐Portuguese ☐Russian ☐Other

Preferred Communication for Appointment Reminders: ☐Automated Text ☐Automated Email
Appointment reminders are a courtesy service; all patients are responsible for remembering their scheduled appointments. We require a minimum of 24-hour notice for cancellations. Failure to do so may result in a charge for the missed appointment.

Guarantor if not the patient (financially responsible party for minor or incapacitated adult):
Name: _____ Date of Birth: ____/_____/____
Relationship to Patient: _____
Address: _____City: _____State:_____
Zip Code:_____
*Preferred Phone Number: ☐Home_____ ☐Cell _____
*Email _____

***Note:** By providing a phone number or email address, you are consenting to being contacted at that number or address regarding your treatment or billing information. In addition, your email will be used to invite you to join our secure patient portal.*

Emergency Contact Information and Relationship to Patient:
Name: _____ Relationship: _____
Phone: _____

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Primary Insurance Name:

Address: _____ City: _____State:_____

Zip Code: _____

Policy ID#: _____ Group/Plan#: _____

Co-Pay: $_____

Subscriber Name: _____

Subscriber Date of Birth: ____/_____/____

Subscriber Employer:

_____

Secondary Insurance Name:

Address: _____ City: _____ State:_____

Zip: _____

Policy ID#: _____ Group/Plan#: _____

Co-Pay: $_____

Subscriber Name: _____

Subscriber Date of Birth: ____/_____/____

Subscriber Employer:

_____

Client Signature: _____**Date:** _____

Parent/Guardian Signature (for minor): _____**Date:** _____

Office Use Only PID: _____	Received by and Date: _____