PATIENT REGISTRATION AND RELEASE OF INFORMATION

Patient's Name: ____

Date of Birth: ______________________ Social Security Number: ______________________

Patient's Address: ____

City: ______________________ State: __________ Zip: ______________

Telephone: ______________________ Sex: __________ Marital Status: ______________

Occupation: ______________ Employer: ______________ Work#: ______________

Person Responsible for the Account: ______________ Relationship to Patient: ______________

Date of Birth: ______________ Work #______________ Employer: ______________

Person to Notify in case of Emergency: ____

Relationship to Patient: ______________________ Telephone: ______________________

PLEASE FILL OUT THE FOLLOWING INFORMATION IF THE PATIENT IS UNDER 18:

Mother/Guardian: ______________ Work #: __________ Employer: ______________

Home Address: ______________________ City, State, Zip: ______________________

Father/Guardian: ______________ Work #: __________ Employer: ______________

Home Address: ______________________ City, State, Zip:______________________

INSURANCE INFORMATION

Name of Insurance: ______________________ Insured Name: ______________________

Insured Date of Birth: ______________ Relationship to Patient: ______________________

Insured SS#: ______________ Group #: ______________ ID#: ______________

MEDICAL HISTORY:

____

____

____

CURRENT PRESCRIPTION MEDICATIONS:

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7115 Forthun Road, Ste 105, Baxter, MN 56425 | email info@northernpsychiatric.com | www.northernpsychiatric.com | tel 218.454.0090 | fax 218.454.0091

PREVIOUS PSYCHIATRIC TREATMENT?: ◻ YES ◻ NO

If yes, when?: ____

With whom?: ____

Medication, if any: ____

____

ALLERGIES:

____

____

____

HABITS: _____ Smoke Tobacco _____ Smoke Other _____Alcohol _____Drug Use _____ Other

RECORDS RELEASE: I hereby authorize the release of any information including medical and billing information, by Northern Psychiatric Associates (NPA) to any referring doctor, referring psychologist, insurance company, clinic selected collection agency or as directed on behalf of myself and/or dependents.

ASSIGNMENT OF BENEFITS: I hereby authorize payment of Medical Benefits directly to NPA for services rendered to myself and/or dependents. I understand that I am responsible for my medical bills including those of my spouse and minor children, regardless of the extent of my insurance coverage.

AUTHORIZATION TO RELEASE INFORMATION: I give consent to NPA to release to any third-party payor responsible for paying benefits on my behalf (including Medicare, Medicaid/Medical Assistance, my private insurer or any other governmental or private payor) any information needed to determine those benefits. I authorize release of my billing information to the clinic selected collection agency. I understand that I have a right to revoke this consent through written notification to NPA.

Date: ______________________________ Signed: ____
(Patient or Responsible Party)

Witness: ____