Worthington Consultation & Behavioral Medicine Revised: 4/19/20

Patient Registration Form

First Name	Middle	Last Name	DOB	Age

Date:		
Address:		
City:		
State:		Zip Code:
Email:	Consent to send appointment reminders	
Cell No.	Consent to send appointment reminders	
Home No.		
Emergency Contact:	Name: Relationship:	Number:
Medication Allergies:		

Insurance Information: *(for reimbursements, prescriptions, and lab orders)*	
Name of Insurer:	
Policy No:	
Policy Holders Name:	
Insurance Co. Address:	
Social Security #	
I authorize payment of medical benefits for pharmacy and laboratory services rendered. I also authorize the release of any medical or other information necessary to process this claim for personal reimbursement pertaining to services rendered.	

X **PATIENT'S SIGNATURE** (or Legal Guardian):	**Date:**

NOTICE TO RECEIVING AGENCY/PERSON: PROHIBITION ON REDISCLOSURE.

This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. This information has been disclosed to you from confidential records protected from disclosure by state law. You shall make no further disclosure of the information without the specific written and informed release of the individual to whom it pertains, or as otherwise permitted by state law.