Allied Behavioral Health Services, Incorporated Registration Information

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Date: ____________________ Client Case/SS # __________________________________

Client Name: ____ DOB: ______________________ Age: _________

Sex: M☐ F☐ Other: _____________ Marital Status: ________________ Ethnicity (Optional): _______________________

Street: ____ City: ____________________ State: __________ Zip: _________

☐ Home Phone: ____________________ ☐ Work Phone: ____________________ ☐ Cell Phone: __________________

Please check all of the above numbers where we may leave a message

Address where we may send confidential correspondence if different from above:

____

Family Physician: ____ Phone: ___________________________

Emergency Contact: ________________________________ Relationship: ________________ Phone: _________________

Party Responsible for Payments: ____ Phone: _________________

<u>Primary Insurance Information</u>

Name of Insured: ____ SS# _______________________ DOB: ___________

Street: _____________________________________ City: _______________________ State: _________ Zip: _____________

Home Phone: ___________________ Work Phone: ___________________ Relationship to Client: ___________________

Insured's Employer: ____ Phone: ______________________

Insurance Company: ____ Phone: ______________________

Policy/Certificate ID#: ______________________________________ Group #: __________________________________

<u>Secondary Insurance</u>

Name of Insured: ____ SS# _______________________ DOB: ___________

Street: _____________________________________ City: _______________________ State: _________ Zip: _____________

Home Phone: ___________________ Work Phone: ___________________ Relationship to Client: ___________________

Insured's Employer: ____ Phone: ______________________

Insurance Company: ____ Phone: ______________________

Policy/Certificate ID#: ______________________________________ Group #: __________________________________

<u>Health Information</u>

Please list current medications: ____

Please list current medical conditions: ____

Please list allergies: _______________________________________ Injuries: ____

Please list past psychiatric medications: ____

Please identify family medical history: ____

Are you here for a work related illness or injury: ☐ Yes ☐ No. If yes, please describe: ___________________________

I certify that I have provided accurate information on this form. I understand that verification of benefits is not a guarantee of payment for my dependent's or my services and I am responsible for any unpaid balance on my account.

____ ________________

Signature of Client Date