## New Horizons Mental Health Services

# REGISTRATION FORM

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| |  | | --- | | Today’s Date: |  client INFORMATION  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Last name: | | | First: | | Middle Initial: |  | | Parent/Guardian (if minor): | | | | | |  | | Birth date: | Age: | Gender: | | Social Security No.: | |   Address: City: State: Zip Code:   |  |  |  |  | | --- | --- | --- | --- | | County of Residence: | Home phone no.: | | Cell phone no.: | | Employer: | Position: | | Employment Start Date: | | Employment Status: (Please select one) □ Full Time (35+ hrs) □ Part Time (21-35 hrs) □ Half Time (20 hrs or less) □ Retired □ Disabled | | | | | □ Unemployed □ Unemployed (Seeking Work) □ Homemaker □ Self-Employed □ Inmate □ Sheltered □ Student □ Other | | | | | Marital Status: (Please select one) □ Divorced □ Married □ Separated □ Single-Never Married □ Widowed □ Other | | | | | Race: (Please select one) □ White □ African American/Black □ Asian □ Other | | | | | Ethnicity: □ Hispanic /Latino □ Non-Hispanic/Latino | | How did you hear about us? | | | Disabilities: | | | | | Client needs the assistance of an interpreter? | | | | | Client needs assistance with visualization of material format? | | | | | Behavioral Health Advance Directives? □ Yes □ No, but like to request information □ No, and declines information | | | |  INSURANCE INFORMATION(Please give your insurance card to the receptionist)  |  | | --- | | Person responsible for bill: Home Phone: | | Address (if different): |   Please indicate primary insurance: □ EAP   |  |  |  | | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | | Policy or Medicaid No: | Group No: | Co-payment: |   Patient’s relationship to subscriber:  Please indicate secondary insurance (if applicable):   |  |  |  | | --- | --- | --- | | Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | | Policy or Medicaid No: | Group No: |  |   Patient’s relationship to subscriber: PRIMARY CARE PHYSICIAN  |  | | --- | | Name of Primary Care Physician: □ Do not have one  Physician Address: Phone number: |   The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Horizons Mental Health Agency. I understand that I am financially responsible for any balance. I also authorize New Horizons Mental Health Services or insurance company to release any information required to process my claims.   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | Patient/Guardian signature |  | Date |  | |