New Patient Enrollment Form for Psychiatry Patients

Facility Name:_____

Admit Date:_____ Room Number: _____

Name:_____

DOB:_____ Male (M) or Female (F):_____

Race:_____ DNR or Full CODE: _____

Social Security Number:_____

Cell Number: _____ Home Number:_____

Address:_____

_____

Insurance Name:_____

Insurance Policy Number: _____

****(Please include a copy of your insurance card with this form)****

Allergies:_____

Responsible Party Name:_____

Address: _____

_____

Cell Number:_____ Home Number: _____

Emergency Contact 1

Name: _____ Relationship:_____

Phone number: _____

Emergency Contact 2

Name:_____ Relationship: _____

Phone number: _____

****Please send an updated MAR and Diagnosis information sheet****
****Please send a copy of Driver Licence and Social Security Card****

If the patient only has one form of insurance, then the patient may be responsible for Deductibles and Coinsurance. If the patient has two forms of insurance or more, then the Deductibles and Coinsurance will be covered by the second insurance and the rest would be adjusted off.

Signature of Responsible Party:

_____