



New Patient Registration Form

Date: _____ Patient ID: _____

Patient Information Patient Full Name: _____

Home address: _____

City: _____ State: _____ Zip: _____

Phone Number: Home: _____ Cell: _____ Email: Primary: _____

Employment/ circle: employed full time student part time student disabled unemployed retired

Employer or School: _____ Grade: _____

Marital Status/ circle: Single Married Divorced Divorce Pending Widowed Engaged Partnered Separated

Date of Birth: _____ Gender/ circle: Male Female

Insurance Information

I am not using any insurance (self-pay) _____ skip the insurance section

Primary Insurance: _____ Policy Number: _____ Group: _____

Policy Holder/ circle: Patient Patient's Parent or Guardian Patient's Spouse If someone other than yourself is the insured party, please

fill out the following section

Name: _____ Phone: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female Employer: _____

Secondary Insurance (if applicable):

Insurance: _____ Policy Number: _____ Group: _____

Policy Holder: Patient Patient's Parent or Guardian Patient's Spouse If someone other than yourself is the insured party, please fill out the following section

Name: _____ Phone: _____

Home address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender/circle: Male Female

Employer _____



New Patient Registration Form 2020

Assignment of Benefits I, the undersigned, assign to HealthyMinds Wellness LLC all medical benefits, and authorize the release of this signature for all claim submission to my insurance company, including Medicare and/or Medicaid. I understand that I am financially responsible for all charges whether paid by insurance. I hereby authorize the facility and the provider to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that health insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of all services, covered and non-covered. I understand that if I terminate my care and treatment, any fees or professional services rendered to me will be immediately due and payable.

Signature_____Date_____