PATIENT REGISTRATION

Patient Information: Today's Date:________________

Patient's Name:____ Date of Birth:________________

Gender: M F Additional category (*please specify*): ____

Patient's Physical Address (*Required*):____________________________ City:_________________ State/Zip:___________

Patient's Mailing Address (*if different*):___________________________City:_________________State/Zip:_____________

Home Phone with Area Code: ( )____________________ Guardian's Work Phone: ( ) ____________________

Guardian's Cell Phone: ( )_________________________ Guardian's E-Mail: _______________________________

If patient is responsible for making/arriving to appointments independently, patient phone: _________________________

Best times to contact guardian are:__________________________ Emergency Contact Person:____________________

Patient's Physician:____________________________________ Physician's Telephone Number: ( ) ______________

Physician's Address (Street, City, State, Zip):____

Patient's Legal Guardian: (*please circle*): Mother Father Both Other (*please specify*):_________________________

Was the patient adopted? (*please circle*): Yes No

Legal Mother's Name:___________________________ Date of Birth:_____________ Home Phone: ( ) ____________

Marital Status: (*please circle*): Single Married Widowed Divorced Separated

If remarried, spouses name:____

Street Address:_____________________________________ City:___________________ State/Zip:_____________

Work Phone: ( )________________________________ Cell Phone: ( ) ______________________________

Legal Father's Name:___________________________ Date of Birth:_____________ Home Phone: ( ) ____________

Marital Status: (*please circle*): Single Married Widowed Divorced Separated

If remarried, spouse's name:____

Street Address:_____________________________________ City:___________________ State/Zip:_____________

Work Phone: ( )____Cell Phone: ( ) ______________________________

If there is another guardian other than the parents of the patient, please complete guardian information below:

Guardian's Name:____________________________ Date of Birth:_____________ Home Phone: ( ) ______________

Street Address:_______________________________________ City:____________________ State/Zip:_____________

Work Phone: ( )_______________________________ Cell Phone: ( ) _______________________________

Relationship to Patient____________________________

Insurance Information

Primary Insurance:

Insured's Name:__________________________________

Insured Social Security Number:_____________________

Insured Birthdate:________________________________

Employer:_______________________________________

Payer/Health Plan:________________________________

Member Number:_________________________________

Policy/Group Number:______________________________

Secondary Insurance:

Insured's Name:__________________________________

Insured Social Security Number:_____________________

Insured Birthdate:________________________________

Employer:_______________________________________

Payer/Health Plan:________________________________

Member Number:_________________________________

Policy/Group Number:______________________________

How did you hear about Gyro Psychology Services?

_____ My Pediatrician referred me

Pediatrician's Name:_______________________________________

_____ My Family Physician referred me

Physician's Name:____

_____ My School Counselor referred me

School: ______________ Counselor's Name: __________________________

_____ Presentation/Workshop

_____ Other:____

_____ Gyro Psychology Website

_____ Go-Gyro-Go Website

_____ Another Website

Website: ______________________

_____ Friend/Co-Worker

_____ Family Member

_____ Gyro Psychology Blog

_____ Gyro Psychology Newsletter

It's okay for Gyro Psychology Services to send me information about upcoming classes, workshops, groups, events, community activities and their monthly newsletter via e-mail. (please circle*: Yes or No *)

Name:____ E-Mail Address:__________________________