Patient Registration

Scott Schlachter, L.I.S.W.
Child & Adult Therapist

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Suite B
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Telephone: 216-464-5500
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Patient Name: _____ Male/Female Date of Birth: _____
Address: _____
_____
_____

Home Phone: _____
Work Phone: _____
Cell Phone: _____

Marital Status: (circle one) single married divorced widow

Social Security Number: _____

Employer: _____ Occupation: _____

Who referred you to this office? _____

May we leave a message at your home with other residents? (circle one) yes no
May we leave a message on your answering machine or voice mail? (circle one) yes no

Emergency Contact: _____
Name: _____
Telephone Number(s): _____
Relationship to Patient: _____

Primary Care Physician: _____
Address: _____ Telephone: _____
May we provide him/her with update information? (circle one) yes no

For Minors Only:
Child lives with: (circle one) both parents mother father

Mother/Guardian: _____
Address (if different): _____
Date of Birth: _____ Home Telephone: _____ Work Telephone: _____

Father/Guardian: _____
Address (if different): _____
Date of Birth: _____ Home Telephone: _____ Work Telephone: _____

Responsible party for insurance and bills: (circle one)
Patient Spouse Parents Mother Father Other
If other, Name and Address of Responsible Party:

_____

_____

Primary Insurance Company _____
Name on Contract: _____
Contract/Policy Number: _____ Group Number: _____
Contract Holder's Date of Birth _____
Contract Holder's Social Security Number: _____
Relationship to Cardholder: (circle one) Self Spouse Dependent
Contract Effective Date: _____

_____

Secondary Insurance Company _____
Name on Contract: _____
Contract/Policy Number: _____ Group Number: _____
Contract Holder's Date of Birth _____
Contract Holder's Social Security Number: _____
Relationship to Cardholder: (circle one) Self Spouse Dependent
Contract Effective Date: _____

PREAUTHORIZATION/PRECERTIFICATION (if required by your insurance carrier)
MUST BE OBTAINED BY THE PATIENT IN ADVANCE OF THE VISIT

Identification of other physicians/health care entities involve with my medical care whom I authorize ongoing release of information for continuity of care:

Provider: _____ Phone: _____
Address: _____
Type of Physician: _____

Provider: _____ Phone: _____
Address: _____
Type of Physician: _____