E.A. HAWSE HEALTH CENTER
REGISTRATION FORM
Behavioral Health

(Please Print)

Today's Date:	**NEW:**	**UPDATED:**

PATIENT INFORMATION

Patient's last name: First: Middle: Email address:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital Status: Single☐ Mar☐ Div☐ Sep☐ Wid☐

Is this your legal name: ☐ Yes ☐ No	If not, what is your legal name?	(Former Name):	Birth Date:	Age:	Sex: ☐ M ☐F

Mailing address:	Social Security No:	Home phone no: ( ) Work phone no: ( ) Cell phone no: ( )

Physical Address:	City:	State:	Zip Code:

Occupation:	Employer:	Employer phone no: ( )

Race: White☐ Black☐ American Indian or Alaskan Native☐
Asian or Pacific Islander☐ Other☐

Ethnic Origin:Hispanic or Latino☐ Not of Hispanic or Latino☐ Declined☐

Language: English☐ Spanish☐ Other☐

Referred by: Family☐ Friend☐ Close to home/work☐
Yellow Pg☐ Other☐

Military Status: Served in Military☐ Did not serve in Military☐

Migrant or Seasonal worker: Yes☐ No☐

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Is this patient covered by insurance? ☐Yes ☐No

Please indicate primary insurance

Subscriber's name:	Subscriber's S.S. no.:	Birth Date:	Group no:	ID no:	Co-Payment: $

Subscriber's Address:	Home Phone: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

Name of Secondary insurance (if applicable):	Subscribers name:	Group no:	ID no:

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address)	Relationship to patient:	Home phone no: ( )	Work phone no: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/clinician. I understand that I am financially responsible for any balance. I also authorize Hawse Health Center or insurance company to release any information required to process my claims. I authorize Hawse Health Center medical and behavioral health staff to consult together and to perform any necessary treatments of diagnostic tests for Medical, Dental and Behavioral Health services.

_____ _____

Patient/Guardian Signature *Date*