NEW PATIENT REGISTRATION

Patient's First Name:	Patient's Last Name:	Date of Birth:	Soc Sec #:
Patient Preferred Name:	Patient Pronouns:	Gender:	
Mailing Address:		Preferred Phone:	Other Phone:
City, State, Zip:		Email:	
Marital Status:		Preferred Language:	
Ethnicity/Race: Asian Native American/Alaskan Native White Hawaiian/Pacific Islander Black/African American Latino/Hispanic Other Prefer not to answer			
Name of Person Completing Form (If Patient is under 18-Years-Old):		Relationship to Patient:	
Guardian Phone (if applicable):		Employment Status:	
Name of School (if Student):		School Phone:	
Primary Insurance Company		**Secondary Insurance**	
Insurance Name:		Insurance Name:	
Policy/Member ID #:		Policy/Member ID #:	
Group #:		Group #:	
Primary Subscriber Name:		Primary Subscriber Name:	

Date of Birth:	Soc Sec #	Date of Birth:	Soc Sec #
Insurance PO Box Address:		Insurance PO Box Address:	
City, State, zip:		City, State, Zip:	

Emergency Contact Name:	Phone:	Relationship:
Primary Care Provider (PCP):	**PCP Phone:**	
Reason for Appointment:		

Preferred Pharmacy:	**Pharmacy Address & Phone:**
Have you seen another Behavioral Health Provider in the past two years? Yes No	

PRIVACY & SECURITY

The above information is true to the best of my knowledge. I understand that Balanced Mental Health of Arizona takes many steps to protect the privacy and security of information that it receives. I also understand that my treatment records are protected under federal law 42 C.F.R. Part 2 Confidentiality of Alcohol and Drug Abuse Patient Records and by state law and cannot be disclosed by Balanced Mental Health of Arizona without my approval.

Signature of Patient / Patient Representative: ____

Date: ________________________