ADVANCED Behavioral Health Services
Child, Adolescent, Adult Psychiatry & Counseling

1952 McDowell Rd Suite 305 Naperville, IL 60563 Phone: 630-689-1022 Fax: 630-689-1023

www.advancedbhs.com

PATIENT REGISTRATION FORM		
Date:	Name of Provider:	
How did you hear about us? (circle one)	Referral (insurance/Doctor/Therapist/Friend/Family); internet; advertisement; other _____	
PATIENT INFORMATION		
Last Name: _____	First Name: _____	Middle Name: _____
Marital Status (circle one): Single/Married/Partnership/Divorced/Separated/Widowed		
Street Address:	City:	State: Zip:
Home Phone:	Cell Phone:	Email Address:
Date of Birth:	Sex: M / F	Social Security #:
Employer:	Occupation:	Work Phone:
Street Address:	City:	State: _____ Zip:_____
Referring Doctor (if required by insurance):		
Notify Primary Care Physician? Yes/No	Name of Primary Care Physician:	Contact Phone:
IN CASE OF EMERGENCY		
Emergency Contact Name:	Home phone #:	Cell phone #:

INSURANCE INFORMATION

Insured's Last Name:	First Name:	Marital Status (circle one): Single/Mar/Part/Div/Sep/Wid

Home Phone:	Cell Phone:	SSN:	Date of Birth:	Sex: M/F

Insurance Company:	Billing Address:	Insurance Phone #:
Policy #:	Group #:	Relationship to Insured: Self / Spouse / Dependent

SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

Insured's Last Name:	First Name:	Marital Status (circle one): Single/Mar/Div/Sep/Wid

Home Phone:	Cell Phone:	SSN:	Date of Birth:	Sex: M/F

Insurance Company:	Insurance Billing Address:	Insurance Phone #:
Policy #:	Group #:	Relationship to Insured: Self / Spouse / Dependent

PREFERRED PHARMACY

Pharmacy Name:

Address:_____City:_____State:_____ZIP:_____

Phone: (___)_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Advanced Behavioral Health Services, those acting on the practice's behalf, and my insurance company to release any information required to process my claims.

Furthermore, I have reviewed the Notice of Privacy Practices provided. I fully understand and accept the terms of this consent.

_____ _____

Patient/Guardian Signature Date