RIVER POINT BEHAVIORAL HEALTH
REGISTRATION FORM

Date:		Arrival Time:

Patient's Name_____ Telephone Number_____

Physical Address_____ City/State/ZIP_____

Mailing Address_____ Patient's S.S.N._____

DOB_____ AGE_____ Please Circle Gender: Female Male

Responsible Party

PRIMARY

Name_____

Address_____

City/State/Zip_____

S.S.N. _____

DOB _____

Employer_____

Work Phone#_____

SECONDARY

Name_____

Address_____

City/State/Zip_____

S.S.N. _____

DOB _____

Employer_____

Work Phone#_____

Primary Insurance Information

Insurance Company Name:_____ Phone#:_____

Address:_____ City/State/Zip_____

Policy Holder's Name_____ Policy Holder's DOB_____

Relationship to Patient_____ Identification#_____

Group Name/Number_____

Did someone refer you to us? (If so, please list name)_____

Presenting Problem (e.g., depression, anxiety, substance abuse)

_____

_____

Are there any medical conditions that we need to be immediately aware of? [ ] Yes [ ] No If yes, please explain

Are you experiencing any of the following: (circle all that may apply)

Sleep Problems	Appetite Problems	Mood Swings	Anxiety	Difficulty with concentration
Memory Loss	Obsessive Thinking	Excessive worry	Relationship Problems	Legal Issues
Medication Problems	Paranoia	Racing Thoughts	Depression	Hyperactivity

Revision: 5/2/12

Patient signature:	Date	Time