Psychological Services of Central Illinois, P.C.
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New Patient Registration Form

Patient Details:

First Name:	Middle Name:	Last Name:	
Date of Birth:	Age:	Gender:	Marital Status:

Contact Information:

Street Address/Apt:		
City:	State:	Zip Code:
Primary Phone:	Type: *(circle one)* HOME CELL WORK	
Alternate Phone: *(if we can't reach the number above)*	Type: *(circle one)* HOME CELL WORK	

Guardianship Information: ❒ The patient is his/her own legal guardian *(skip the rest of this section)*

Primary parent/contact: *(parent/guardian the patient resides with)*	Other parent:
Relationship: *(Circle all that apply)* BIOLOGICAL STEP FOSTER ADOPTIVE ***FATHER MOTHER OTHER:_____***	Relationship: *(Circle all that apply)* BIOLOGICAL STEP FOSTER ADOPTIVE ***FATHER MOTHER OTHER:_____***
Preferred Phone:	Preferred Phone:
Non-custodial parent(s): *(please list)*	
If you are divorced or separated, what are the custody arrangements?	
Does the child have any contact with this parent? please explain:	

Emergency Contact:

Name:	Phone Number:

Insurance Information: *(we must have all this information in order to bill your insurance)*

Primary	**Secondary**
Subscriber Name:	Subscriber Name:
Relationship to Patient:	Relationship to Patient:
Date of Birth:	Date of Birth:
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
Group Number:	Group Number:
ID Number:	ID Number:

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Family Information: *(list all other members living in the same household with the patient)*

Name:	Age:	Relationship to Patient:	Name:	Age:	Relationship to Patient:

Providers:

	Name:	Agency:	Specialization:
Primary Care Physician			
Other			
Other			

Hospitalizations: ❒ The patient has not been hospitalized

Facility:	Dates:	Reason:	Comments:

Mental Health Services: ❒ The patient has not had previous counseling/mental health treatment

Provider:	Dates:	Reason:	Comments:

Previous Evaluation/Testing:

Has the patient been previously evaluated by a Psychiatrist, Psychologist or Developmental Specialist? ❒YES ❒NO
If yes, when and with whom?
What was the result?
If you were referred for psychological testing, how might an evaluation help you/your child/family?

Medications: ❒ The patient is not currently taking any medications

Name:	Dosage:	Frequency:	Taken For:

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Allergies: ❒ The patient has no documented allergies

Allergy:	Date discovered:	Reaction:	Comments:

Health History: *(please list all known medical conditions as well as who in the family is affected)*

Condition:	Relationship:	Condition:	Relationship:

Reason for Consultation:

Please describe the problem/concerns that brought you here:
What are you hoping to learn?
What are your goals for treatment?

Authorizations/Billing/Consent for Treatment:

1. I authorize the use of this information on all insurance submissions made on my behalf;
2. I authorize the release of information to my insurance company(s) for the purposes of billing my insurance;
3. I authorize insurance payments to be made directly to my service provider;
4. I understand that I am solely responsible for all amounts due for services rendered, and that providing my insurance information does not relieve me of this obligation in the event that services are not covered;
5. I understand that if I "no-show" for an appointment, or fail to give 24 hours advance notice of cancellation that I may be charged the full amount for the appointment, and that this amount will not be billed to my insurance;
6. I understand that my insurance deductible, co-insurance and/or co-payment are due at the time services are rendered unless I have made other arrangements with my service provider in advance;
7. I have received a copy of the Notice of Privacy Practices and been given the opportunity to ask questions about it.

Signatures:

	Signature:	Date:
Patient: *(12 and up)*		
Witness:		
Parent/Guardian:		
Parent/Guardian:		