



REGISTRATION

Today's Date ____ / ____ / ____

Patient Information

Name: _____ Name by Which You Prefer to Be Addressed: _____

Address: _____ City: _____ ST: _____ Zip Code: _____

Date of Birth ____ / ____ / ____ Social Security Number ____ - ____ - ____

Phones: Home: _____ Cell: _____

Where would you like appointment reminder calls? Home Work Cell No Calls

If Employed:

Name of Employer: _____ Occupation: _____

Address: _____ City: _____ ST: _____ Zip Code: _____

Phone: ____ -- ____ --- _____

Emergency Information:

Name: _____ Relationship: _____

Address: _____ City: _____ ST: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

If Patient is under the age of 18 who is the legal guardian?

Name: _____ Relationship: _____

Address: _____ ST: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Date of Birth ____ / ____ / ____ Social Security Number ____ - ____ - ____

Additional Information:

Primary Care Physician _____ Address _____ Phone ____ - ____

May we contact your Physician if necessary? No Yes

Please list all medications that you are currently taking:

Please list any allergies:

Method of Payment Self Pay EAP Insurance Other

If payment is by insurance please complete the section below:

Name of Insurance Company _____

Insurance ID Number _____ Group Name and Number _____

Phone Number of Company _____

Is Preauthorization required? No Yes Is Physician Referral required? No Yes

Who is the Insured Member if not the Patient

Name: _____ Relationship: _____

Address: _____ ST: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Date of Birth __ / __ / ____ Social Security Number __ __ __ - __ __ - ____

Employer: _____

Employer Address: _____

I DO give my permission for Decatur Psychological Associates, P.C., to bill my insurance company for services rendered.

I DO NOT give my permission for Decatur Psychological Associates, P.C., to bill my insurance company for services rendered.

Name (please print) _____

Signature _____

Date _____

Please complete the following if you are associated with the Illinois Great Rivers Conference of the United Methodist Church:

I am: Clergy Clergy Spouse Clergy Offspring Clergy Family Member

Clergy Status: Active Student Retired On leave Other _____

I serve (or live) in the: (District)

- Cache River Embarras River Illinois River Iroquois River
- Kaskaskia River LaMoine River Mississippi River Sangamon River
- Spoon River Vermilion River

Names of clergy and family members are not shared outside of this office for any reason. Decatur Psychological Associates simply reports demographic data (number of clergy or clergy family members, clergy status and district) for billing purposes. Thank you for your assistance.

Kindly give 24 hour notice if you cannot keep this appointment. No Shows will be billed.

Welcome to Decatur Psychological Associates, P.C.