

Patient Registration

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. All provided information is confidential and is released only with your consent. Please assist us by providing the following information:

Today's Date _____ How did you hear about our Practice? _____

Patient Name	Date of Birth	Sex	Age
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Parent/Guardian (if patient is minor)/designated power of attorney:	Patient Social Security#	Driver License#
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Single <input type="checkbox"/>	Married <input type="checkbox"/>	Divorced <input type="checkbox"/>	Widowed <input type="checkbox"/>	Cohabiting <input type="checkbox"/>	Separated <input type="checkbox"/>
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Home Address	City	ST	Zip
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Email Address	Phone Number	Cell Phone Number
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May we Contact you by text messaging? Yes No

Occupation	Employer's Name (if under 18 please list guardian's employment)
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Employer's Address	City	ST	Zip
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Spouse's Name	Spouse's Employer Name and Phone Number
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Primary Care Physician	Address	Phone Number
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May we contact your Primary Care Physician? Yes No

Emergency Notification

Name	Relationship	Phone Number
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Home Address	City	ST	Zip
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Nearest Relative Not Living with you

Home Telephone	Work Telephone
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Financial Information: Person Responsible for Fees

Name _____ Telephone _____

Address _____ City _____ ST _____ Zip _____

Insurance Company _____ Claims Address _____

Subscriber's Name _____ Subscriber's Date of Birth _____ Subscriber SSN _____

Member ID Number _____

Secondary Insurance _____ Claims Address _____

Subscriber's Name _____ Subscriber's Date of Birth _____ Subscriber SSN _____

Medicare Patients Only

One Time Authorization: I request that payment of authorized Medicare benefits be made to me or on my behalf to Wichita Psychiatric Consultants for any services furnished by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for the payable for related services.

X _____
Patient Signature _____ Date Signed _____

All Patients

Consent to Treat: I hereby consent for treatment or services to be provided by Wichita Psychiatric Consultants. I also certify that no guarantee of assurance had been made as to the results which may be obtained

Concerning Payment: I give permission for WPC to discuss insurance, billing and accounting information with

Print Name _____ Relationship _____

Release of Medical Information: I consent to the release of my medical records by Wichita Psychiatric Consultants for the purpose of review or audits, or of necessary insurance purposes, to authorized representatives of my insurance company.

Insurance Payment of Benefits: I authorize payment of benefits to be made on my behalf to Wichita Psychiatric Consultants for medical services provided.

Financial Agreement: I understand that I am responsible for all fees regardless of insurance coverage.

X _____
Signature (Parent/Guardian if patient is under 18/or DPOA) _____ Date Signed _____

Worker's Compensation

Were you injured on the job? Yes No Have you informed your employer? Yes No

Date of injury: _____

Worker's Compensation carrier name and phone number: _____

Are the claims for the injury involved in a lawsuit or other litigation? Yes No

If yes, attorney's name, address and phone number: _____