

New Perspectives

ADULT

A Counseling and Consultation Group

REGISTRATION FORM

CLIENT INFORMATION									
Name					Referred to New Perspectives by:				
Street									
City				State			Zip		
Phone (H) ()			(W) ()			Other ()			
Date of Birth			Gender (circle) M F		SSN				
Marital Status (Check box to right)		Single		Married		Divorced		Other	
Relationship to Policyholder		Self		Spouse		Child		Other	
Employment Status		Full Time		Part Time		Unemployed			
School Status		Full Time		Part Time		Does not attend school			
Is treatment related to		Employment		Auto Accident		Other Accident		None of these	
POLICYHOLDER/INSURANCE INFORMATION									
<i>If secondary coverage is available, please request additional insurance form</i>									
Name				Member ID No.			Grp. No.		
Street						SSN			
City				State			Zip		
Phone (H) ()			(W) ()			Other ()			
Date of Birth			Gender (circle) M F		Authorization No.				
Insurance Company						Phone ()			
Street				City			State		Zip
Employer									
FOR OFFICE USE ONLY									
Intake Date				Therapist		Referral		Code	
Client Amount/Copay 1st Visit				Primary Dx					
Client Amount/Copay 2nd Visit				Other Payment Information					
Benefits				Deductible		Amt. Met		Visits/Year	
Utilization Review						Max \$/Yr.		Verified	

AD = Advertising ATTY = Attorney EAP = Employee Assistance Program CL = Clergy GW = Good Work MC = Managed Care
MD = Physician MISC = Miscellaneous OT = Other Therapist SCH = School

In order for us to bill your insurance company we must have complete information about your insurance. If there is some information that you do not have available at this time, please call it in to the office as soon as possible. If we are lacking information, we are unable to bill your insurance company. You will be held financially responsible for all charges incurred.

(410)356-3344 / Fax: (410)356-4459

(410)751-9205 / Fax: (410)751-6191

McDonogh Crossroads
6 Park Center Court / Suite 103
Owings Mills, Maryland / 21117

Hunter Professional Centre
904-A Washington Road
Westminster / Maryland / 21157



Patient's Name _____ Date of Birth _____

Physician _____ Phone _____

Physician's Address _____

Other Family Members	Relationship	Date of Birth

Person to contact in case of emergency: Name: _____

Phone Number _____ Relationship _____

A. Please list the problems with which you want help:

1. _____
2. _____
3. _____

E. Have you received any other therapy or special treatments (psychological counseling, psychiatric help, speech therapy, medications, diets, etc.)? Yes No

If so, please describe below:

Approximate Date(s)	Type of Treatment	Name/Address of Provider

Medical Issues

Hospitalizations _____

Allergies _____

Chronic Medical Conditions (i.e. asthma, ear infections) _____

Current Medical Concerns _____

Current Medications and Dosage _____
