Macks Psychology Group

Patient Registration Form

Patient Information

Patient Name: _____ Birthdate: _____

Street Address: _____

City, State, Zip: _____ County:_____

Gender: _____ Patient's School: _____

Patient's Phone # (if applicable): _____cell home business (circle one)

Patient's Email (if applicable): _____

Primary Care Physician: _____Physician Phone #: _____

Referral Source: Physician School Employer Insurance Company Internet Search

Friend Other: _____

Family Information

Parent 1 Name: _____ Phone number: _____

Street Address (if different from patient's): _____

Email: _____Parent occupation:_____

Parent 2 Name: _____ Phone number: _____

Street Address (if different from patient's): _____

Email: _____Parent occupation:_____

Parents' marital status: _____ Married _____ Separated/Divorced _____ Never Married _____ Other

Please list the names and ages of other people living in the home_____

_____

_____

Reason for Appointment

Please check the primary reason(s) for which you have requested this appointment:

____ Academic or learning struggles

____ Job performance struggles

____ Attention, focus or memory problems

____ Hyperactive, overly talkative or impulsive

____ Speech/Articulation struggles

____ Language/Communication struggles

____ Social difficulties

____ Adherence to medical needs

____ Fine motor and/or coordination

____ Defiance or oppositional behavior

____ Anger, aggression or tantrums

____ Mood/Depression concerns

____ Anxiety, fear or worry

____ Grief/Loss

____ Stress management

____ Coping with physical pain/illness

____ Sensory processing/sensory integration

Other _____

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Patient Insurance Information Form

Insurance Information

Primary Insurance Carrier:_____

Policy ID #: _____ Group #: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's Address (if different from patient's): _____

Policy Holder's Phone Number (if different from patient's): _____

Policy Holder's SSN: _____ Policy Holder's Employer: _____

Secondary Insurance Carrier (if applicable): _____

Secondary Insurance Policy ID#:_____ Group #:_____

Secondary Insurance Policy Holder's Name:_____