PATIENT REGISTRATION FORM
Kimberly Butler, PMHNP

Patient		Today's Date
☐New ☐Existing		/ /

PATIENT INFORMATION

Last Name	First Name	Middle

Home Address	Mailing Address

City	State	Zip Code	City	State	Zip Code

Gender	Date of Birth	Age		Marital Status (Circle One)
☐M ☐F	/ /			Single Married Divorced Widowed

Home Phone	Cell Phone	Work Number

Email Address	
May we leave voicemail messages?	At Home: ☐Yes ☐No At Work: ☐Yes ☐No

IN CASE OF EMERGENCY

Emergency Contact 1	Home Phone	Work Phone	Relationship
May we communicate with this person about your health?		☐ Yes	☐ No

Emergency Contact 2	Home Phone	Work Phone	Relationship
May we communicate with this person about your health?		☐ Yes	☐ No

EMPLOYMENT INFORMATION

Employment Status

☐Full Time ☐Part Time ☐Unemployed ☐Act. Military ☐Self Employed ☐Retired ☐Student ☐Other

Occupation	Employer	Employer Phone

Employer Address (if known)	City	State	Zip Code

PHYSICIAN INFORMATION

Referring Provider/Counselor	Primary Care Provider

(Continued On Other Side)

What Pharmacy do your use for prescriptions? ____

Would you prefer to be reminded about your appointments by: ☐ Email ☐ Text ☐ Phone call

INSURANCE INFORMATION

(We will need to make a copy of your insurance card when you arrive to the office)

Primary Insurance Company	Group Number	ID Number	Co-Pay

Patient's Relationship To Subscriber: ☐Self ☐Spouse ☐Child ☐Other: ___________________________

Subscriber Information

Last Name	First Name	Date of Birth	Employer

INSURANCE INFORMATION

Secondary Insurance Company	Group Number	ID Number	Co-Pay

Patient's Relationship To Subscriber: ☐Self ☐Spouse ☐Child ☐Other: ___________________________

Subscriber Information

Last Name	First Name	Date of Birth	Employer

FINANCIAL RESPONSIBILITY (If other than patient)

Last Name	First Name	Middle

Mailing Address	Phone Number

City	State	Zip Code	Relationship to Patient

FINANCIAL AGREEMENT- SIGNATURE REQUIRED

I hereby authorize Kimberly Butler, PMHNP and/or her designate to provide medical treatment and release information pertaining to treatment for insurance purposes. I understand that I am financially responsible for payment of all services at the time they are rendered unless other payment arrangements have been established. I understand that I am responsible for any appointment missed and understand a charge will be incurred for an appointment not kept or cancelled with less than a 24-hour notice.

Patient Signature

X ______________________________

Date

____

Responsible Party Signature

X ______________________________

Date

____