**Riverpoint Psychiatric Associates- ADULT Patient Registration** Date: _____

Name: _____ Sex: M ___ F ___
first middle last

**EMAIL address** _____

Phone #'s: home _____ work _____ cell _____

Address: _____ City: _____ State: __ Zip: _____

Birthdate: _____ Social Sec. #: _____ Marital status: M_ S_ D_

Referred by: _____

Employer: _____
name address phone

Spouse's name: _____ Spouse's phone: _____ Spouse SSN: _____

Spouse's employer: _____
employer's name address phone

*Emergency contact:* _____*Relat. to patient:* _____

*Address:* _____

*Phone#'s: home* _____ *work* _____ *cell:* _____

**Insurance Info:**
#1 Company name: _____ Subscriber #: _____Group #: _____

**Subscriber's name: _____ Relationship to patient: _____**

**REQUIRED: Subscriber's date of birth: _____ Subscriber's gender: M __ F __**

**Person responsible for bill:**

_____ _____
(name) (address)

Soc sec #: _____ Phone #'s: home: _____ work: _____ cell: ____
**Race**: Asian_, Black _, White _, Other (specify) _____
**Ethnicity**: African-American_, American_, Chinese_, Filipino_, Hispanic_, Japanese_, Korean_, Mexican_, Puerto Rican_, Other (specify) _____
**Language**: English_ Spanish_ Other (specify) _____