

BridgePointe Psychological and Counseling

PATIENT REGISTRATION

Patient Information

Date: _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Home # _____ Cell # _____ Work # _____ Leave a Yes
Message No

Birthdate _____ Circle one
M / F Social Security # _____

Personal Email Address (if available) _____

Primary Care Physician _____ Phone# _____

Primary Care Physician Address _____

Employer Name _____ Employer Address _____

Insurance Information

Primary Ins. Name _____ Secondary Ins. Name _____
ID # _____ ID # _____

Policyholder Information (if different than patient)

Primary Policyholder	Secondary Policyholder
Name _____	Name _____
Address _____	Address _____
City _____	City _____
Home # _____	Home # _____
SS# _____ DOB: _____	SS# _____ DOB: _____
Employer _____	Employer _____

Responsible Party (if not the patient or policyholder)

Name _____ Relationship _____
Address _____
City _____ State _____ Zip Code _____
Home # _____ Cell # _____ Work # _____
SS# _____

Emergency Contact

Name _____ Relationship _____
Home # _____ Cell # _____ Work # _____