PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS
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1490 E Foremaster Dr., Suite 340 – St. George, Utah 84790

NEW PATIENT REGISTRATION FORM

Today's Date:					
PATIENT INFORMATION					
Patient's last name: First:			Middle Initial:	Marital status:	
Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Maiden/Former name:	Birth date:	Age:	Sex: ○ M ○ F
Address:					
Social Security no.:	Home phone no.:		Cell phone no.:		
Occupation:	Employer:		Employer phone no.:		
Chose clinic because/referred to clinic by (Please choose one option): ○ Doctor's Name ○ Other: Please list:					
Other family members seen here:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:		
Is this person a patient here? ○ Yes ○ No		Is this patient covered by insurance?	○ Yes ○ No		
Occupation:	Employer:	Employer address:	Employer phone no.:		
Please indicate primary insurance: Other:					
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: Other:					
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber: Other:					
IN CASE OF EMERGENCY					
Name of local friend or relative :	Relationship to patient:	Home phone no.:	Work phone no.:		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Premier Psychological Counseling & Consulting, PC. I understand that I am financially responsible for any balance. I also authorize Premier Psychological Counseling & Consulting, PC or insurance company to release any information required to process my claims.

Patient/Guardian signature _____ Date _____