PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS

o: 435.216.9290 | 435.865.9119 | f: 435.865.9115
1490 E Foremaster Dr, Suite 340 – St. George, Utah 84790

New Patient Registration Form

Patient Information

LAST name	FIRST name	MIDDLE name	Birth Date (mm/dd/yyyy)	Sex

Social Security Number	Marital Status	Employment Status	Preferred Language	Religion

Sexual Orientation	Gender Identity	Address 1 (Physical)

Mailing Address (If different than physical address)	City	State	Zip Code

Preferred Phone Number Type Cell, Home, Work, Other	Preferred Phone Number	Email Address

How would you like to receive appointment reminders? Text, Email Phone Call	If you chose "Text," please enter the phone number we should use to send text reminders.

Employer Name	Employer Phone Number

How did you hear about our office?
Doctor, Family/Friend, Psych Today, Google, TV, Billboard, Radio, SGHW Magazine, Website, Social Media, Other:

Emergency Contact Information

Name of Contact	Relation to Patient	Address (include city & state)	Best phone number to use

Insurance Information

Primary Insured LAST name	Primary Insured FIRST name	Insurance Company Name

Primary Insured address (physical)	Primary Insured address (mailing)	City	State	Zip

Primary Insured DOB (mm/dd/yyyy)	Primary Insured SSN	Primary Insured Phone Number	Relationship to Patient

Subscriber/Member ID	Group Number	Visit Co-Pay	Name of Employer	Employer Phone Number

IF APPLICABLE

Secondary Insured LAST name	Secondary Insured FIRST name	Insurance Company Name

Sec Insured DOB (mm/dd/yyyy)	Sec Insured SSN	Sec Insured Address, (include City, State Zip)	Sec Insured Phone No.	Relationship to Patient

Subscriber/Member ID	Group Number	Visit Co-Pay	Name of Employer	Employer Phone Number

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 and Consulting, PC or my insurance company to release any information required to process my claims.

Patient or Guardian Signature	Date (mm/dd/yyyy)	