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Honolulu, HI 96814

New Patient Registration Form

Client's Name_____Date_____
Social Security #_____
Birthdate_____
Address_____
City_____Zip_____
Home Phone_____Work Phone_____Cell_____
Email: _____
Employer:_____
School:_____Emp.Address_____

Background Information:

Please state your reason(s) for seeking behavioral health services at this time.
_____
_____
_____
_____

How were you referred to us?
_____
_____
_____

Have you previously received behavioral health services? Please include the name of provider seen and approximate dates of services.
_____
_____
_____

Who is your Primary Care Physician?_____

Last Physical Examination and Significant Findings?
_____
_____

Have you informed your Primary Care Physician of your/your child's behavioral health concerns? Yes_____ No_____

Are you/your child taking any medications now? _____ If yes, please list all medications and supplements taken.

_____
_____

Please complete all history items below that apply to you/your child.

Hospitalizations:_____
_____
_____

Serious or Frequent
Illnesses:_____
_____
_____
_____
_____

Childhood
Illnesses:_____

Allergies:_____

Head
Injuries:_____
Seizures:_____
Previous Mental Health treatment?_____
_____
_____
_____
_____

Provider?_____ Diagnosis
Treated_____

Financial Agreement:

_____I understand that individual sessions are 45-60 minutes unless otherwise discussed.
_____I understand and agree that regardless of my insurance status, I am responsible for any balance on my account for services rendered.
_____I understand that Fees and charges are due on the date of services rendered.

My Insurance carrier is_____

My Insurance Number is_____

_____I agree to pay at each session.

____ I agree that I will be fiscally responsible for all sessions that I do not cancel before 24 hours of the scheduled appointment time.

Client Name_____

Client Signature_____

Parent/Guardian
Name_____

Parent/Guardian Signature: _____