**NEW PATIENT REGISTRATION**

 **CRAIG M. VOORHEES, PH.D.**

 **10004 KENNERLY RD. SUITE 310A**

 **ST. LOUIS, MO 63128**

**Please fill out form completely and clearly, as it is needed to complete your claims.**

**DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME: LAST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MIDDLE I.\_\_\_\_\_\_\_\_\_\_GENDER\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MARITAL STATUS: SINGLE\_\_\_\_\_\_MARRIED\_\_\_\_\_\_PARTNERED\_\_\_\_\_\_SEPARATED\_\_\_\_\_\_\_DIVORCED\_\_\_\_\_\_\_WIDOWED\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_ AGE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_\_ ZIP CODE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CELL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDITIONAL PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE INDICATE YOUR 1ST AND 2ND PREFERENCE FOR APPOINTMENT REMINDER CALLS:**

**HOME PHONE\_\_\_\_\_\_\_\_\_\_CELL PHONE\_\_\_\_\_\_\_\_TEXT MESSAGE\_\_\_\_\_\_\_EMAIL\_\_\_\_\_\_\_\_**

**EMERGENCY CONTACT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REFERRED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CIRCLE ONE: PCP, SPECIALIST, FAMILY, FRIEND, INSURANCE, OTHER**

**PRIMARY CARE PHYSICIAN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INSURANCE: PRIMARY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF THE PATIENT IS NOT THE SUBCRIBER, GIVE NAME OF SUBCRIBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AND SOCIAL SECURITY OF SUBCRIBER\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF YOUR VISIT IS COVERED BY EAP, PROVIDE AUTHORIZATION # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# OF VISITS\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ASSIGNMENT OF BENEFITS & RESPONSIBLITIES**

The above information is true to the best of my knowledge. I authorize my insurance be paid directly to the doctor. I understand that I am financially responsible for any balance not covered by the insurance carrier. I also authorize

Dr. Voorhees to release any information required to process my claims. I agree to pay all co-pays at the time of service and all amounts applied to my deductible upon receipt of statement or at the time of service if I have a large deductible that has not been met. If this account is assigned to a collection agency or an attorney for collection and/or suit, I will pay your court cost and your attorney fees.

**\*\*I understand that a 24 hour notice is required to cancel appointments that I have scheduled. I will be charged $25 for the first late cancellation or “No Show”, $50 for the second and the full $120 hourly fee thereafter. \*\***

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_