Evolutionary Wellbeing

Psychological & Counseling Services for optimal mental, physical & relational health

Registration

Patient Information

First Name M.I. Last Name

Home Address Street

City State Zip

Date of Birth Age Sex

Social Security Number Marital Status

Home Phone Work Phone Cell Phone

Email

Highest Grade Completed Diploma or Degree

Religious Preference (optional)

Employer or School

Address

About Your Spouse (or Parents of Child)

Spouse/Parent Names Phone

Employer

Address

Family Members with whom you are living

_____

Name Relationship Age

_____

Name Relationship Age

_____

Name Relationship Age

_____

Name Relationship Age

_____

Name Relationship Age

Financially responsible person

( ) Self ( ) Spouse ( ) Parent ( )Other_____

_____

Name Date of Birth

_____

Address

_____

Employer Phone

How did you find out about our services?

( ) Friend ( ) Doctor ( ) Attorney ( ) Minister ( ) School

( )Counselor ( )Other _____

Please specify

May we thank them for referring you? Yes No

If Yes,

_____

Name

Family Physician

_____

Name Phone

_____

Address

Previous Mental Health Care

_____

Doctor's Name/Institution Dates

_____

Doctor's Name/Institution Dates

Current Medications

_____

Medication Dose Reason

_____

Medication Dose Reason

_____

Medication Dose Reason

Allergies Yes No

_____

Please Identify

Current Health Problems

_____

_____

_____

Have you had any major surgery? Yes No

_____

_____

Anything else you would like us to know?

_____

_____

Health Insurance

_____

Primary Health Insurance Company

_____

Address

_____

ID No. Group No. Subscriber and DOB

Consent, Authorization, and Assignment Agreement

I, _____, understand that I am financially responsible for all charges whether or not paid by the insurance. If a provider for my insurance, I here by authorize Evolutionary Wellbeing and my Clinician to apply for benefits on my behalf for services rendered. I request that payment will be made directly to my Clinician. I affirm that the information provided regarding my insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any other claim to any insurance company. A copy of this consent, authorization and assignment agreement may be used in place of the original. This agreement will remain in effect until revoked by me in writing. I agree to assume responsibility for all charges incurred should collection of this balance become necessary. I agree to assume responsibility for all charges incurred should collection of this balance become necessary, including court costs and attorney fees. I also understand that I will be charged $25.00 for any checks returned by my bank. I have received a copy and understand my rights regarding the HIPPA Notice of Privacy Practices.

Date_____ Signature_____