# REGISTRATION FOR ST. VINCENT STRESS CENTER

**TODAY'S DATE:** *PLEASE PRINT CLEARLY*

**PATIENT INFORMATION**

| PATIENT LAST NAME: | FIRST NAME | FULL MIDDLE NAME(S) | PREVIOUS NAME(S): | |
|---|---|---|---|---|
| SS# / / | BIRTH DATE: | AGE: | SEX: | RELIGION: |
| WHO REFERRED YOU TO US: | | | DO YOU HAVE AN ADVANCE DIRECTIVE: ___ YES ___ NO | |
| HOME ADDRESS: | CITY | STATE | ZIP | COUNTY |
| HOME PHONE: ( ) | | WORK PHONE: ( ) | | |
| CELL PHONE: ( ) | | PATIENT PROVIDING DEPOSIT: YES / NO COMMENT: | | |

WHAT PHONE(S) MAY WE LEAVE A VOICE MAIL MESSAGE, IF NECESSARY? HOME: YES / NO WORK: YES / NO CELL: YES / NO

| PRIMARY CARE PHYSICIAN: | PHYSICIAN'S PHONE NO. |
|---|---|
| EMPLOYER'S NAME: | OCCUPATION: |
| EMPLOYER'S ADDRESS: | |

| *CIRCLE ONE* | *CIRLCE OR COMPLETE ONE* | *COMPLETE (SEE CARD)* | *CIRCLE ONE* | *COMPLETE IF APPLICABLE* |
|---|---|---|---|---|
| **MARITAL STATUS:** | **RACE:** | **ETHNICITY:** | **EMPLOYMENT STATUS** | **STUDENT** |
| ♦ NEVER MARRIED<br>♦ MARRIED<br>♦ LEGALLY SEPARATED<br>♦ DIVORCED<br>♦ WIDOWED | ♦ AFRICAN AMERICAN<br>♦ ASIAN<br>♦ CAUCASIAN<br>♦ HISPANIC<br>♦ OTHER_____ | **LANGUAGE:** | FULL-TIME PART-TIME<br>NOT EMPLOYED RETIRED<br>SELF-EMPLOYED DISABLED<br>ACTIVE MILITARY | GRADE:_____<br>SCHOOL ATTENDING: |

| EMERGENCY CONTACT PERSON: [IF ADOLESCENT, SHOULD BE PARENTS] | RELATIONSHIP TO PATIENT: | HOME PHONE: ( ) |
|---|---|---|
| HOME ADDRESS: | | WORK PHONE: ( ) |
| EMPLOYER NAME/ADDRESS: | | CELL PHONE: ( ) |
| 2ND EMERGENCY CONTACT PERSON: | RELATIONSHIP TO PATIENT: | HOME PHONE: ( ) |
| HOME ADDRESS: | | WORK PHONE: ( ) |
| EMPLOYER NAME/ADDRESS: | | CELL PHONE: ( ) |
| GUARANTOR (= PATIENT IF OVER 18 YEARS OF AGE; OR = PARENT SIGNING CONSENT IF PATIENT UNDER 18 YEARS OF AGE) : | RELATIONSHIP TO PATIENT: | HOME PHONE: ( ) |
| HOME ADDRESS: | | WORK PHONE: ( ) |
| EMPLOYER NAME/ADDRESS: GUARANTOR SSN: | | CELL PHONE: ( ) |
| PRIMARY INSURANCE: | | RELATIONSHIP TO PATIENT: |
| POLICY HOLDER'S NAME: | | OCCUPATION: |
| POLICY HOLDER'S HOME ADDRESS: | | HOME PHONE: ( ) |
| EMPLOYER'S NAME AND ADDRESS: | | WORK PHONE: ( ) |

| POLICY HOLDER'S DATE OF BIRTH: | POLICY HOLDER'S SOC SEC #: | ACCT/ GROUP #: | INSURANCE ID #: | INSURANCE PHONE: |
|---|---|---|---|---|
| | | | | |

| SECONDARY INSURANCE: | | RELATIONSHIP TO PATIENT: |
|---|---|---|
| POLICY HOLDER'S NAME: | | OCCUPATION: |
| POLICY HOLDER'S HOME ADDRESS: | | HOME PHONE: ( ) |
| EMPLOYER'S NAME AND ADDRESS: | | WORK PHONE: ( ) |

| POLICY HOLDER'S DATE OF BIRTH: | POLICY HOLDER'S SOC SEC #: | ACCT/ GROUP #: | INSURANCE ID #: | INSURANCE PHONE: |
|---|---|---|---|---|
| | | | | |

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD(S) AND A COPY OF YOUR DRIVER'S LICENSE

**PLEASE NOTE: We obtain insurance benefits as a courtesy. This is not a guarantee of what fees your insurance will pay.**