# CENTER FOR POSITIVE CHANGE, LLC

## Patient Registration Form

| Provider: |
|---|
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| Name (Last, first, middle initial) | | Social Security Number | Gender Identity |
|---|---|---|---|
| Birth Date | Marital status & Spouse/Partners name if applicable | Mobile Phone | Home/Work Phone |
| E-mail Address | Mailing Address | | |

| Occupation | Employers Name |
|---|---|
| | |

| Emergency Contact's Name & Address | Emergency Phone |
|---|---|
| Primary Care Physician & Phone | Referral Source |
| List Medications & Allergies (use back of sheet if needed) | |

Did You Get Insurance Authorization Prior to Your First Visit? _____ YES _____ NO

| **Primary Insurance Company Name** | ID Number | Group Number |
|---|---|---|
| Address | Effective Date | Phone Number |
| Policy Holder's Name | Relationship to Patient | Holder's SS# |
| **Secondary Insurance Company Name** | ID Number | Group Number |
| Address | Effective Date | Phone Number |
| Policy Holder's Name | Relationship to Patient | Holder's SS# |

I authorize communication with my primary care physician _____ YES _____ NO

I authorize payment of medical benefits to Center for Positive Change, LLC and I understand that I am responsible for any amounts NOT covered by insurance benefits.

Signature _____ Date _____