Psychiatry Associates of Kansas City, P.A.
Patient Registration

Acct #_____

Doctor:_____ Date:_____ ☐ NEW ☐ UPDATE

PATIENT INFORMATION

Name: _____ Employer: _____

Address: _____ Business Address: _____

_____ Work Phone: (_____) _____

Home Phone: (_____) _____ School / Grade: _____

Cell Phone: (_____) _____ May we contact you at Work: ☐ Yes ☐ No

Date of Birth: _____ Marital Status: ☐ Married ☐ Separated ☐ Divorced

Soc. Sec. #: _____ ☐ Widow ☐ Single ☐ Partner

Email Address: _____

SPOUSE OR NEAREST RELATIVE ☐ Spouse ☐ Parent ☐ Guardian ☐ Other

Name: _____ Employer: _____

Address: _____ Business Address: _____

_____ Work Phone: (_____) _____

Home/Cell Phone: (_____) _____ May we contact him/her at Work: ☐ Yes ☐ No

Date of Birth: _____

Soc. Sec. #: _____

PERSONAL INFORMATION

_____
Referred by

_____
Street Address City State

(_____)_____
Phone

Please List All Current / Previous Treatment of Counselors / Therapists / Psychiatrists

_____ _____
Name Dates Seen

_____ _____
Name Dates Seen

MEDICAL HISTORY

_____ _____
Primary Care Physician Date of Last Visit

_____
Street Address City State

(_____)_____
Phone

Please List Any Allergies and Reaction: _____

_____

Please List All Current Medications and Conditions: _____

_____

_____

PRIMARY INSURANCE INFORMATION

_____ (_____)_____
Name of Insurance Company Insurance Phone Number

_____
Street Address/P.O. Box # City State Zip code

_____ _____
Certificate or ID Number Group Number

_____ _____ _____ _____
Policyholder/Subscriber Name Relation to Patient Date of Birth Social Security Number

_____
Policyholder's Place of Employment

SECONDARY INSURANCE INFORMATION

_____ (_____)_____
Name of Insurance Company Insurance Phone Number

_____
Street Address/P.O. Box # City State Zip code

_____ _____
Certificate or ID Number Group Number

_____ _____ _____ _____
Policyholder/Subscriber Name Relation to Patient Date of Birth Social Security Number

_____
Policyholder's Place of Employment

PATIENT (Parent or Guardian) IS FINANCIALLY RESPONSIBLE FOR ANY SERVICES NOT COVERED BY THEIR POLICY. CO-PAYS AND/ PAYMENT IS EXPECTED AT TIME OF SERVICES.

CONSENT FOR TREATMENT

I hereby consent to treatment by Psychiatry Associates of Kansas City, P.A. I will not be given treatment against my wishes and may discuss my refusal with the attending physician.

Signed: _____ Date: _____
Patient (parent if patient is a minor)

AUTHORIZATON TO RELEASE INFORMATION

I hereby authorize Psychiatry Associates of Kansas City, P.A. to release medical and/or mental health information necessary for insurance reimbursement.

Signed: _____ Date: _____
Patient (parent if patient is a minor)

I hereby authorize Psychiatry Associates of Kansas City, P.A. (PAKC) to release a letter and/or copy of the initial assessment, to my Primary Care Physician or the Provider that referred me to PAKC. This authorization will automatically expire one year from the date signed below. **(COMPLETE THE BELOW SECTION ONLY IF YOU WANT THIS INFORMATION MAILED TO THE OTHER PROVIDER!)**

Physician: _____ Phone: _____

Address:_____ City_____ State _____ Zip Code _____

Signed: _____ Date: _____
Patient (parent if patient is a minor)