NWP
2364 Washington Street
Newton, MA 02462-1440

Newton-Wellesley Psychiatry
PATIENT REGISTRATION

(Please Print)

Phone: 617-332-2047
Fax: 617-332-7341
http://www.nwpsych.org
contact@nwpsych.org

Today's Date:		Clinician:	Reg #:

PATIENT INFORMATION

Patient's First Name:	Middle:	Last:	Social Security #: _ _ _ - _ _ - _ _ _ _	Marital status:
Street address:			Date of Birth: _ _ / _ _ /_ _ _ _	Age:	Sex: ❑ M ❑ F
City:	State:	ZIP Code:	Please check preferred contact phone #	Home phone #: ❑ ( )
Referred by :	Allergies:		Mobile phone #: ❑ ( )	Work phone #: ❑ ( )
Primary Care Physician:	Physician phone #: ( )	Pharmacy: Phone: ( )	DX Codes (provider use):	

Race: ❑ Caucasian ❑ African American ❑ Asian ❑ Other ❑ Prefer not to answer	Ethnicity: ❑ Latino/Hispanic ❑ Other ❑ Prefer not to answer	E-mail Address _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Is the patient covered by insurance? ❑ Yes ❑ No

Primary insurance company: Member ID:	Subscriber's name:	Date of Birth: _ _ / _ _ /_ _ _ _	Social Security #: _ _ _ - _ _ - _ _ _ _
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____			
Secondary insurance company (if applicable): Member ID:	Subscriber's name:	Date of Birth: _ _ / _ _ /_ _ _ _	Social Security #: _ _ _ - _ _ - _ _ _ _
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____			

Person responsible for any balance after insurance, if different:	Date of Birth: _ _ / _ _ /_ _ _ _	Social Security #: _ _ _ - _ _ - _ _ _ _	Home phone #: ( )
Address:	City:	State:	ZIP Code:	Cell phone #: ( )

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone #: ( )	Cell phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Newton-Wellesley Psychiatry and give permission to release any of the above information required to process my claims. I also understand that, if no one else is listed, I am financially responsible for any balance after insurance.

Patient/Guardian signature *Printed Name* *Date*

CONFIDENTIAL NEW PATIENT INFORMATION

Please answer the following questions as completely as you feel comfortable:

NAME: AGE: DOB:

1. What medications (names, doses) are you taking (include all)?

2. What psychiatric medications (names, doses) have you taken in the past?

3. Please answer these questions and use the back of the form to explain if you wish:

   A. Highest level of education finished:

   B. Most recent occupation:

Are you working now?

Are you receiving disability payments?

   C. Do you have or have you had any legal problems?

   D. Have you had medical or legal problems from alcohol or drugs?

Have you been treated in a detox?

   E. Do you own or have access to firearms?

I agree and consent to participate in treatment at Newton-Wellesley Psychiatry.

I understand that if several Newton-Wellesley Psychiatry clinicians are involved in providing my care, they will routinely and freely share information about me.

I understand I will be charged for missed appointments unless I cancel **at least 48 hours in advance**. Missed appointments are not covered by insurance.

I understand the confidentiality policy.

All my questions about policies and procedures have been answered.

SIGNATURE: _____ DATE:_____