YOUNG MINDS PSYCHIATRY

Anas Alkhatib, M.D.

REGISTRATION FORM

(Please Print – ALL INFORMATION MUST BE COMPLETED)

Date:_____

PATIENT INFORMATION

Patient's Last Name	First	Middle	Mr / Mrs Ms / Miss	Marital Status (Circle One) Single / Mar / Div / Sep / Wid
Date of Birth	Age	SSN	Cell phone	Sex: MALE / FEMALE
Home Address	City	State	Zip Code	
Mail Address	City	State	Zip Code	Work Phone / Home Phone
Occupation	Employer/School	Employer/School Address, City, State, Zip Code		
Primary Care Physician	Physician Phone	Physician Address		
Email:	Best way to contact: Email Phone	Pharmacy number:		

Other Family Members a Patient of this office? YES / NO If Yes, please provide Patient Name:

RESPONSIBLE PARTY

Person Responsible for Payment	Date of Birth	Mailing Address (if different)	Home Phone
Relationship to Patient	Is responsible party also a patient here? YES / NO	Cell Phone	
Occupation	Employer	Employer Address, City, State, Zip Code	
Primary insurance	Policy Holder Name	Policy Holder DOB	
Policy ID	Group ID	Insurance Number	

IN CASE OF EMERGENCY

Name of Nearest Relative NOT Living with you	Relationship to Patient	Home Phone	Cell Phone

The above information is true to the best of my knowledge

X_____ _____

PATIENT/GUARDIAN SIGNATURE DATE