Connecticut Addiction Medicine
Way to Recovery

REGISTRATION FORM

Incomplete demographics can result in claims delays/denial, forcing responsibility onto the patient/responsible party.
Please fill out form completely

PERSONAL INFORMATION

Name _____ (First / Middle / Last)

Sex: ◯ M ◯ F

Marital Status (Check one)
◯ Single ◯ Married ◯ Divorced ◯ Widow ◯ Other._____

Is this your legal name? ◯ Yes ◯ No

If not, what is your legal name? _____

Former Name _____

Birth Date: ___/___/_____

Age: _____

Address: _____ (Street / City / State / Zip Code)

◯ Homeless

Social Security Number ___-___-____

Home Phone (___) _____

Work Phone (___) _____

Cell Phone (___) _____

Employment Status: ◯ Employed ◯ Homemaker ◯ Full-Time Student ◯ Disabled ◯ Retired ◯ Self-Employed ◯ Stay-at-home-Parent ◯ Part-Time Student ◯ Unemployed

Employer or School: _____

Occupation: _____

Employer Phone (___) _____

Employer Address:

Have you ever been treated by our office before? ◯ Yes ◯ No

Other family members seen here:

IN CASE OF EMERGENCY

Emergency Contact Name: _____

Relationship: _____

Phone : (_____) _____

GUARANTOR INFORMATION

GUARANTOR Name (If you are NOT responsible for bill): _____

Guarantor DOB: ___/___/_____

Guarantor Phone: (___) _____

Sex: ◯ M ◯ F

Guarantor Address (if different): _____ (Street / City / State / Zip Code)

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Primary Insurance Carrier Name: _____

Insurance Carrier Address (if unknown. leave blank): _____

Policy Holder's Name: _____

Policy Holder's SSN: ___-___-____

Policy Holder's DOB: ___/___/_____

Group #: _____

Policy #: _____

Policy Holder's Address: _____

Policy Holder Phone Number: (_____) _____

Sex: ◯ M ◯ F

Your Relationship to Policy Holder:: ◯ Self ◯ Spouse ◯ Child ◯ Other

Secondary Insurance Carrier Name: _____

Insurance Carrier Address (if unknown, leave blank): _____

Policy Holder's Name: _____

Policy Holder's SSN: ___-___-____

Policy Holder's DOB: ___/___/_____

Group #: _____

Policy #: _____

Your Relationship to Policy Holder:: ◯ Self ◯ Spouse ◯ Child ◯ Other

The above information is true to the best of my knowledge. I understand that I am financially responsible for any unpaid balance. I also authorize Connecticut Addiction Medicine to release any information required to process my claims.

Signature: _____ Date _____