

## Orlando Psychiatric Associates Inc.

923 Sand Lake Road  
Orlando, FL 32809  
Telephone: (407) 851-5121  
Fax: (407) 851-0439

10125 West Colonial Drive Suite 204  
Ocoee, FL 34761  
Phone: 407-532-4940  
Fax: 407-532-4946

### REGISTRATION INFORMATION

(PLEASE PRINT)

Home Phone \_\_\_\_\_

\_\_\_\_\_

Last Name	First Name	Initial
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Responsible Party (if a minor) \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  Single  Married  Widowed  Separated  Divorced

Employed  Full-Time Student  Part-Time Student Patient's School Name \_\_\_\_\_

Patient Employed By \_\_\_\_\_

Business Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Spouse (or responsible party) Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Business Name and Address \_\_\_\_\_

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Spouse's Social Security # \_\_\_\_\_

Do you have Medical Insurance?  No  Yes If yes,

Name of Primary Insurer \_\_\_\_\_

Contact # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Name of Secondary Insurer (if any) \_\_\_\_\_

Contact # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Please list other doctors you have seen in the past 5 years:

1. \_\_\_\_\_ City/State \_\_\_\_\_

(General Practitioner, Specialist, or other)

Reason for seeing \_\_\_\_\_

2. \_\_\_\_\_ City/State \_\_\_\_\_

(General Practitioner, Specialist, or other)

Reason for seeing \_\_\_\_\_

\_\_\_\_\_

Allergies and Drug Reactions

What medication are you taking at this present time? \_\_\_\_\_

Have you seen a psychiatrist before? \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I, the undersigned, have insurance coverage with \_\_\_\_\_  
Name of Insurance Company

and assign directly to Orlando Psychiatric Associates all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

\_\_\_\_\_  
Signature of Insured/Guardian Date