THE PANS CENTER

Patient Registration Form

Completed By: _____
Relationship to Patient: _____
Date Completed: _____/_____/_____

Patient Name: _____ Age ____ Date-of-Birth: _____/_____/_____
(Last) (First)

If patient 18+: Phone: _____ - _____ - _____ Email: _____

Address: _____City _____ Zip _____ State _____

Mailing Address: _____City _____ Zip _____ State _____
(Check if same ☐)

Sex Assigned at Birth: _____ Gender Identity: _____ Pronouns: _____

Preferred Language: _____

Caregiver Name: _____ Home Phone: _____ - _____ - _____

Email: _____ Cell Phone: _____ - _____ - _____

Occupation: _____ Work Phone: _____ - _____ - _____

Relationship to Patient: _____ Lives with Patient? Yes ____ No ____ Part-time ____

Legal Guardian of Patient? Yes ____ No ____ Preferred Language: _____

Caregiver Name: _____ Home Phone: _____ - _____ - _____

Email: _____ Cell Phone: _____ - _____ - _____

Occupation: _____ Work Phone: _____ - _____ - _____

Relationship to Patient: _____ Lives with Patient? Yes ____ No ____ Part-time ____

Legal Guardian of Patient? Yes ____ No ____ Preferred Language: _____

Parents' Marital Status: ____Married ____Partnered ____Separated ____Divorced ____Widowed

If patient is under 18 and parents are separated or divorced:

Who has physical custody? _____ Legal custody? _____

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Do both parents agree to evaluation and treatment by The PANS Center? Yes ____ No ____

Religious Preference? _____

Siblings (including half or step and regardless of age or location) and anyone else living in your home:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Primary Care Provider: _____ Practice: _____

Address: _____City _____ Zip _____ State _____

Ph: _____ - _____ - _____ Fax: _____ - _____ - _____ Email: _____

Frequency of Appointments: _____ Last seen: _____

Psychiatric Prescriber: _____ Practice: _____

Address: _____City _____ Zip _____ State _____

Ph: _____ - _____ - _____ Fax: _____ - _____ - _____ Email: _____

Frequency of Appointments: _____ Last seen: _____

Therapist: _____ Practice: _____

Address: _____City _____ Zip _____ State _____

Ph: _____ - _____ - _____ Fax: _____ - _____ - _____ Email: _____

Frequency of Appointments: _____ Last seen: _____

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Other Doctors or Care Providers (e.g, Specialists, Therapists, Nutritionists, Ed. Advocate, etc.)

Name: ______________________________ Practice: ______________

Ph: ____ - ____ - ______ Fax: ____ - ____ - ______ Email: ____________________

Address: ____________________ City ______________ Zip ______ State ____

Specialty/Role: ______________________________ Last seen: __________

Name: ______________________________ Practice: ______________

Ph: ____ - ____ - ______ Fax: ____ - ____ - ______ Email: ____________________

Address: ____________________ City ______________ Zip ______ State ____

Specialty/Role: ______________________________ Last seen: __________

Name: ______________________________ Practice: ______________

Ph: ____ - ____ - ______ Fax: ____ - ____ - ______ Email: ____________________

Address: ____________________ City ______________ Zip ______ State ____

Specialty/Role: ______________________________ Last seen: __________

Name: ______________________________ Practice: ______________

Ph: ____ - ____ - ______ Fax: ____ - ____ - ______ Email: ____________________

Address: ____________________ City ______________ Zip ______ State ____

Specialty/Role: ______________________________ Last seen: __________

NOTE: Attach an additional page if more space is needed.

THE PANS CENTER

Pharmacies

Pharmacy (Local): _____ Phone: _____ - _____ - _____

Address: _____City _____ Zip _____ State _____

Pharmacy (Mail Order): _____ Phone: _____ - _____ - _____

Address: _____City _____ Zip _____ State _____

Pharmacy (Other): _____ Phone: _____ - _____ - _____

Address: _____City _____ Zip _____ State _____

Insurance

Please note that The PANS Center does not currently have insurance contracts or bill to insurance companies (see Payment Policy). We ask for insurance information to assist in the management of prescriptions, and in anticipation of billing insurance companies on your behalf in the future.

Primary Insurance Plan: _____ ID: _____

RxBIN: _____ RxPCN: _____ RxGROUP: _____

Address: _____City _____ Zip _____ State _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Secondary Insurance Plan: _____ ID: _____

RxBIN: _____ RxPCN: _____ RxGROUP: _____

Address: _____City _____ Zip _____ State _____

Subscriber Name: _____ Subscriber DOB: _____/_____/_____

Please attach a picture of your insurance card, both front and back

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