SEQUOIA
MENTAL HEALTH SERVICES, INC.

New Patient Enrollment Form

Name _____ Date _____

Name at Birth: _____

Social Security Number _____ ☐Male ☐ Female Date of Birth: _____

Address _____
Street City State Zip code

Home Phone: _(____)_____ Cell Phone: _(_ ___)_____ Email: _____

Race/Ethnicity: _____ Marital Status: _____

Primary Language: _____ Interpreter Needed: ☐Yes ☐ No

Highest Grade Completed: _____ Currently Enrolled in School or Training: ☐Yes ☐ No

Currently Employed: ☐Yes ☐ No If no, have you sought employment: ☐Yes ☐ No Veteran ☐Yes ☐ No

Household Monthly Income: _____ ☐Declined to answer Source of Income: _____

Emergency Contact: _____ Phone: _____

Responsible Party (Guardian or Payee if applicable)

Person responsible for the account_____ Relationship _____

Address_____Home Phone_____

City_____ State_____ Zip_____ Work Phone_____

Insurance Information (Including OHP, Medicaid, etc.)

Primary Insurance (Attach copy of card or verification)

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Insurance company_____

Insurance company address _____

Identification #_____ Group #_____Union or local #_____

Name of employer_____ Phone_____

If Medicare coverage:

Medicare Managed Care Provider _____ ID #_____

Medicare Prescription Drug Plan _____ ID #_____

Secondary Insurance (Attach copy of card or verification)

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Insurance company_____

Insurance company address _____

Identification #_____ Group #_____Union or local #_____

Name of employer_____ Phone_____

If Medicare coverage:

Medicare Managed Care Provider _____ ID #_____

Medicare Prescription Drug Plan _____ ID #_____

Insurance Release

*******By signing below, I, the patient or responsibly party, certify that the information provided on this form is true to the best of my knowledge. I accept responsibility for all charges incurred on this account and agree to pay all bills at the time of service, unless other arrangements have been made. I authorize Sequoia to release any information to process insurance claims. I also authorize my insurance claim to be paid directly to Sequoia. If payment for services is not received within 30 days of billing, I will be sent a second notice and offered a payment plan. If there is no response to the payment letter within 30 days of receipt, I understand I may be discharged from services at Sequoia Mental Health Services, Inc. *******

X_____ _____

Signature of Beneficiary, Guardian or Personal Representative — Date

_____ _____

Please print name of Beneficiary, Guardian or Personal Representative — Relationship to Patient