Randy Sellers, M.D., P.A.
General Psychiatry and Psychotherapy
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REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Dr. ❑ Ms.	The name I prefer to be called:

Home Phone:	Work Phone:	Cell Phone:	Birth date: / /	Age:	Sex: ❑ M ❑ F

The best time to contact me is: ❑ AM ❑ PM on my ❑Home phone ❑Work phone ❑Cell phone

Street address:	P.O. Box:

City:	State:	Zip Code:	Emergency Contact Person:	Emerg. Contact Phone:

Occupation:	Employer:	Employer phone no.: ( )

If student, Name of Parent:	If student, Name of School:	School City/State:

Chose Dr. Sellers because/Referred by (please check one box):	❑ Dr.	❑ Therapist	❑ Website

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Insurance Plan	❑ Other

PERSON RESPONSIBLE FOR PAYMENT

❑ **Same (Skip this section)**	❑ Parent	❑ Guardian	❑ Other

Responsible party last name: First:	Preferred contact phone number:

Responsible party street address: ❑ Same P.O. Box: City: State: Zip Code:

INSURANCE INFORMATION

(*Fill out the section below only if you are using Cigna Behavioral Health, BCBS, or Medicare health insurance to pay for your visits. Dr. Sellers will file insurance for these companies.)

Primary Insurance:	❑ Cigna Behavioral Health	❑ BCBS	❑ Medicare

Subscriber's last name:	First name:	Birth date: / /	Policy Number:	Group Number:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	**Office Use:**

Subscriber's employer or ❑ Unemployed:	Employer address:	City:	State:	Zip Code:

Name of secondary insurance (if applicable):	Subscriber's name:	Policy number:	Group number:

***Please sign below if using: Cigna Behavioral Health, BCBS, or Medicare**	***Please also sign below only if using: Cigna Behavioral Health or BCBS (<u>If Medicare, do not sign</u>.)**
The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Randy Sellers MD PA or my insurance company to release any information required to process my claims.	I authorize my insurance benefits be paid directly to the physician.
Patient/Guardian signature *Date*	*Patient/Guardian signature* *Date*