NEW STORY BEHAVIORAL HEALTH
6400 ARLINGTON BLVD. | SUITE 920
FALLS CHURCH, VA 22042
703.241.2664 | WWW.NEWSTORYBH.COM

NEW STORY
BEHAVIORAL HEALTH

WITH CURT THOMPSON, MD

PATIENT REGISTRATION FORM

Date _____ Referred by _____

Personal Information (if couple, please write insured person's name and information)

Last Name, First M.I. _____ Gender _____ Age _____ D.O.B _____

Home Phone _____ Work Phone _____ Cell Phone _____

Street Address _____

City _____ State _____ Zip Code _____

Email _____

Please select your preferred means of contact:
Cell phone ○ Home phone ○ Work phone ○ Mail ◉

Would you like to be added to our distribution list?:
Yes ◉ NO ○

If you indicate that you prefer to be contacted by phone, you consent to receive calls from New Story Behavioral Health at the phone number(s) above, including your wireless number. The content of calls may include confidential healthcare information. You understand that your wireless carrier may charge you for these calls and that these calls may be generated by an automated dialing system.

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Separated
Student Status: ○ Non ○ Full time ○ Part time
Employment Status: ○ Full time ○ Part time ○ Retired ○ Not employed

Please list the names and ages of all other people living in your home:

Name _____ D.O.B _____ Relationship _____

Name _____ D.O.B _____ Relationship _____

Name _____ D.O.B _____ Relationship _____

Name _____ D.O.B _____ Relationship _____

Emergency Contact:

Name _____ Relationship _____ Phone Number _____

Please note that we submit the first page of all patient registration forms, and the information provided (address, cell phone number, birthdate, etc.), to our third-party billing service in order to facilitate the management of patient accounts. By signing below, you acknowledge that you have received this notice and consent to the release of the information on this page:

Signature _____ Date _____

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Payment Information

Who is responsible for payment, if other than yourself? If you are here as a family or couple, please designate one person for billing purposes. Please inform your clinician if you are a Medicare recipient.

Financially Responsible Person

Relationship to Patient: ○ Self ○ Parent ○ Spouse ○ Other

Street Address

City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Please indicate if you are currently enrolled in Medicaid or Medicare: ☐ Medicaid ☐ Medicare

Employment Information

Employer | Occupation

Street Address

City | State | Zip Code

Phone

Medical Information

Medical conditions for which you see a doctor on a regular basis:

Allergies to medication:

Current medications including dosages and dates medications were started:

Primary Care Physician | Phone

Specialist | Phone