

Transcultural Care
Olamide Alabi, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
Phone 662 234 5317 Fax 662 269 6089
Email: info@transcultural-care.com

Patient Registration Information

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ SSN _____ DOB: ___ / ___ / ___ Gender: M ___ F ___ Other ___

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (If Different Than Above): _____

Primary Phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Work phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Place of Employment: _____ Please circle one: Full time Part time

Email: _____

Primary Care Provider: _____ Phone: _____

Who were you referred by?: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Emergency Contact Relation: _____

Billing Address: Check if same as above ()

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to patient: _____

DOB _____ Driver's License _____ State _____

Address: _____ City _____ State _____ Zip _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

Primary Phone: _____ Message Ok? Yes / No Work phone: _____

I acknowledge that I have received a copy of Transcultural Care's Privacy Practices (otherwise known as HIPPA).

Patient name or guardian/parent: _____ Date: _____

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CONFIDENTIAL

Insurance information:

Please bring your insurance card(s) and ID to your first appointment. The primary insurance is usually based on the earliest birthday of the subscribers.

Primary Insurance: _____

Customer Service Phone Number: _____

Place of Employment: _____

Subscriber/Member Name (if other than patient): _____

DOB: _____ SS# _____

Subscriber Id # _____ Group/Policy # _____

Relationship To Patient/Patient: _____

Please check with your insurance company to find out your benefits and responsibilities, including if you have a deductible and the amount of your co-pay.

Please be prepared to pay your co-pay and deductible (if applicable) at the time of the visit. We accept cash, checks, all major credit cards, and HSA/FSA cards.

Deductible (if applicable) _____ New Deductible begins _____

Co-pay or Co-insurance _____

I authorize Transcultural Care LLC to bill my insurance company as well as release any information needed to do so and assign benefits Transcultural Care LLC.

Printed Name: _____ Signature: _____ Date: _____

Responsible party (If Under 18): _____