CONFIDENTIAL

Transcultural Care
Olamide Alabi, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
Phone 662 234 5317 Fax 662 638 3880
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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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): ____