Sunrise Psychiatry, LLC
721 Long Point Road
Suite 408B
Mt. Pleasant, SC 29464
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Sunrisepsychiatry.com

PATIENT REGISTRATION AND INFORMATION

HOW DID YOU HEAR ABOUT US: _____ DATE: _____

REASON FOR VISIT: _____ CHART #: _____

PATIENT INFORMATION

Patient's Name: _____
First *Last* *Middle Initial* *Preferred Name*

Address: _____
Street *City and State* *Zip Code*

SS#: _____ DOB: _____ / _____ / _____ Age: _____

Sex: ( ) *Male* ( ) *Female* Marital Status: ( ) *Married* ( ) *Single* ( ) *Divorced* ( ) *Widowed*

Cell: (_____) _____ Home: (_____) _____ Work: (_____) _____

Email Address: _____

Preferred Method of Contact ( ) Cell ( ) Home ( ) Work ( ) Email

Employer/School: _____

Emergency Contact: _____ Phone #: (_____) _____

MEDICAL/PHARMACY INFORMATION

Primary Care Physician: _____ Phone: (_____) _____

Preferred Pharmacy: _____ Phone: (_____) _____

FINANCIAL RESPONSIBILITY/SUBSCRIBER'S INFORMATION

Person Responsible for Payment/Bill: ( ) Self ( ) Parent ( ) Spouse ( ) Legal Guardian ( ) Other: _____

Subscriber/Responsible Party's Name: _____

SS#: _____ DOB: _____ / _____ / _____ Sex: ( ) *Male* ( ) *Female*

Subscriber/Responsible Party's Address: _____
(if different from Patient's) *Street* *City and State* *Zip Code*

Cell: (_____) _____ Home: (_____) _____ Work: (_____) _____

INSURANCE BENEFITS

Primary Insurance: _____Policy #: _____ Group #: _____

Effective Date of Policy: _____ Mental Health Benefits: Y N In Network: Y N

Secondary Insurance: _____Policy #: _____ Group #: _____

Effective Date of Policy: _____ Mental Health Benefits: Y N In Network: Y N