# DSM Therapeutic & Wellness Center

PMB 190 590 Farrington Hwy #210 + Kapolei, HI. 96707 + (808) 825-4955

Today's Date: _____

## REGISTRATION FORM

Name: _____ _____ ___

First Last M.I.

Address:_____

Street and Number City State Zip

Phone:_____ Age:_____ Social Security No.: _____-_____-_____

Email : _____

Date of Birth:_____/_____/_____ Gender: _____ Marital Status: _____

Spouses Name:_____

Primary Care Physician (PCP) _____ Phone Number: _____

Current Medications: _____

_____

Reason for Visit: _____

Did someone refer you? If yes, who?_____ Phone: _____

Emergency Contact Name: _____ Relationship: _____

Phone:_____ Address:_____

**Insurance Information**

**(Please bring insurance card and a Photo ID with you on your first visit)**

Primary Insurance Company:_____

Policy #:_____ Group:_____ Member ID #:_____

Subscriber's Full Name: _____ DOB: _____

Relationship to Subscriber: _____

Secondary Insurance Company:_____

Policy #:_____ Group:_____ Member ID #:_____

Subscriber's Full Name: _____ DOB: _____

Relationship to Subscriber: _____

**Complete this section if the client is a minor**

Parent/Legal Guardian Name: _____

Address:_____ Phone: _____

Occupation: _____ Employer: _____

Work Address: _____ Work Phone: _____

Minors School: _____ Grade: _____