NOVANT HEALTH

Forsyth Medical Center

3333 Silas Creek Parkway
Winston-Salem, NC 27103

Novant Behavioral Health Outpatient
175 Kimel Park Drive Suite 100
Winston Salem, NC 27103

We are glad you have chosen Novant Behavioral Health for your Behavioral Health needs.

It is our desire that your experience with our staff would be an excellent and remarkable one. We are committed to making this happen for you.

If you are attending:	**Arrive:**
Mental Health or Substance Abuse Day Programs	By 8 am on your first day
Substance Abuse Evening Program	By 5:30 pm on your first day
Individual Counseling	15 minutes prior to your first appointment
DBT Skills Training Group	30 minutes prior to your first day

Enclosed you will find a map to our office and registration forms which need to be completed before arriving for your appointment. We are also including paperwork for your review to be signed once you arrive for your appointment.

Please bring your insurance card(s) and a photo ID such as your driver's license. Also bring with you the name of your family physician, physician's practice name and phone number.

If you have any questions prior to your appointment or you need to reschedule, please call us at 336-718-3550. Please call 24 hours ahead of time if you need to cancel. Example: Monday appointments would need to be cancelled on Friday.

You can also contact us through our Behavioral Health Call Center by calling 336-718-3550.

Thank you for taking the time to read this information and completing the appropriate forms.

We genuinely look forward to being of service.

Novant Behavioral Health Outpatient Staff

NOVANT BEHAVIORAL HEALTH OUTPATIENT REGISTRATION INFORMATION
175 Kimel Park Drive, Ste. 100
WINSTON SALEM, NC 27103

Today's Date: _____

PATIENT: Date of birth _____ SS# _____ Race _____ Sex _____ Marital Status: **M S D Sep Widow**

Last Name _____ **First Name** _____ **Middle Name** _____

Maiden Name _____ Street Address_____ City _____

State _____ ZIP _____ Home Phone (_____) _____ Cellular (_____) _____

Preferred Email Address: _____ County that you live in _____

ADVANCED DIRECTIVES	YES	NO	INFO UNAVAIL	DOES NOT APPLY
The Patient is an organ donor.				
The Patient has a living will.				
The Patient has a health care power of attorney.				

Please provide the first and last **name** of your Family Physician or Primary Care Physician _____

Physician practice name _____ Ph# _____

Were you born in the U.S.? ☐ Yes ☐ No If no, where were you born? _____

IF YOU ARE A COLLEGE STUDENT, DO YOU ATTEND – Check one: ☐ Full Time ☐ Part Time Check one: ☐ Day ☐ Night

Name of College _____ City _____ State _____

Patient Employer (If **retired**, please give former employer) Name _____

Phone # (_____) _____ Position _____

Street Address _____

City _____ State _____ Zip _____

Employment Status
Check 1: ☐Full Time ☐Part Time
☐FMLA ☐Retired ☐Disabled
Disability Date _____

BILLING INFORMATION: If you are on your parent's or spouse's insurance policy we need the following information.

Spouse **or** Parent **Name** _____ Job Title _____

Spouse **or** Parent **Employer** _____ Phone (_____) _____

Street Address _____ City _____ State _____ Zip _____

Spouse or Parent SS# _____

Employment Status
Check 1: ☐Full Time ☐Part Time
☐FMLA ☐Retired ☐Disabled
Disability Date _____

Spouse /Parent Date of Birth _____

For security please provide the following information:
Year & Model of Car _____ Color _____ License Plate # _____

*****EMERGENCY CONTACT INFORMATION*****

Name _____ **Relationship to Patient** _____ **Home PH (_____)** _____

Work PH (_____) _____ **Cellular (_____)** _____

Street Address _____ **City** _____ **State** _____ **ZIP** _____