



# New Patient Registration

## Patient Information:

Date: \_\_\_\_\_

Note: Please spell name exactly as spelled on your insurance card

Full Legal Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Identifies As: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Interpreter Needed: \_\_\_\_\_ Military or First Responder Status: \_\_\_\_\_

Preferred Location: Ammon Idaho Falls Pocatello Rexburg

## Insurance Information:

Are you participating in an Employee Assistance Program: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_ Insurance Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Policy Holder's Address: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_ Insurance Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Policy Holder's Address: \_\_\_\_\_

## What to expect on your first appointment?

1. Children 17 and younger need to be accompanied by a Parent and / or Legal Guardian. **\*\*NO EXCEPTIONS\*\***
2. Please arrive 15 minutes prior for new patient appointments.
3. Please note that Case Managers should accompany developmentally or severely mentally ill clients.

New patients will begin with a Comprehensive Diagnostic Assessment (CDA), and a 45-minute appointment with a Licensed Mental Health Counselor. This initial session reviews your background, current concerns, mental health history, and daily functioning. It helps the counselor understand your strengths, challenges, and goals in order to create a clear, personalized treatment plan.

## How did you hear about Pearl Health Clinic? (Please select one)

Primary Care Doctor  Relative  Friend  Community Event  Website  Social Media  Newspaper

Other: \_\_\_\_\_



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**Services Requested: Please check all services that the patient is interested in**

- **Case Management** – Helps individuals with mental health needs access community services and supports for independent living. (Medicaid only)
- **Community-Based Rehabilitation Services (CBRS)** – Teaches daily living and coping skills to help individuals function independently at home and in the community. (Medicaid only)
- **Counseling** – Short-term therapy to help individuals manage life challenges and personal growth.
- **EMDR Therapy** – A specialized therapy that helps reduce stress and trauma symptoms.
- **Family Support** – Provides guidance from experienced caregivers to help families strengthen and support their children’s emotional needs.
- **Medication-Assisted Treatment (MAT)** – Combines medication and therapy to treat substance use disorders and support recovery.
- **Neurofeedback Therapy** – Uses brainwave monitoring to help improve focus, mood, and overall well-being.
- **Neuropsychological/Psychological Testing** – Evaluates memory, personality, and thinking skills to support diagnosis and treatment planning.
- **Psychiatric Medicine** – Provides medical evaluation and medication management for mental health conditions.
- **Respite Care** – Offers short-term relief for families caring for a child with serious emotional or behavioral needs.
- **Spravato (Esketamine) Therapy** – In-clinic nasal spray treatment for depression that hasn’t improved with other medications.
- **Skills Training and Development (STAD)** – Group sessions that build social, coping, and daily living skills.
- **Substance Abuse Program** – Outpatient treatment that includes group and individual therapy with medication management.
- **Transcranial Magnetic Stimulation (TMS)** – A non-medication treatment for depression using gentle magnetic stimulation.
- **YES Case Management** – Coordinates individualized service plans for youth enrolled in the YES program.
- **Therapy Groups -**
  - Depression/Anxiety Group
  - Adult Connection Group
  - Grief and Loss Group
  - LGBTQ+ Group
  - Women's Retirement Group
  - Parenting Group
  - Substance Abuse Group

**Requested Provider:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

**Consent for Treatment.** I voluntarily consent to and authorize Pearl Health Clinic and its employed or affiliated physicians, practitioners, and staff (collectively “Providers”) to render health care services:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_