Patient Registration Form

Date:___/___/_____

Name:_____
(Last) (First) (M.I.)

Name of Parent/guardian (for minor patient):

_____
(Last) (First) (M.I.)

Telephone: (H)_____; (O)_____

(M)_____

Email address:_____

Address:_____

_____

D.O.B.: ____/____/_____ **Age:**_____

Marital Status: __Never Married __Married __Domestic Partnership

__Separated __Divorced __Widowed

Emergency Contact:_____
(Name) (Relationship)

Best Tel. #s:_____

Referred by:_____

Current Psychiatrist (if applicable): _____

Telephone Number:_____

Have you previously received mental health services—psychotherapy, psychiatric care, etc.?

___No

___Yes--previous therapist/practitioner(s):_____

_____

Are you currently taking any prescription medications?

__No

__Yes. Please list:_____

_____

Past psychiatric medications? (names & dates):_____

_____

_____

Significant Medical History & Dates (trauma, hospitalization, surgery etc.):

_____

_____

Do you have Medicare? ___Yes ___No