Patient Registration Form

**Therapist:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Patient Demographic Information

|  |  |
| --- | --- |
| **Patient Name:** | **Social Security #:** |
| **Street Address:** | **Date of Birth:** |
| **City, State, Zip Code:** | **Home Phone:** |
| **Gender:** | **Work Phone:** |
| **Email Address:** | **Mobile Phone:** |
| **Primary Physician:** | **Psychiatrist (if any):** |
| **Emergency Contact Person:** | **Emergency Contact Phone:** |
| **How did you hear about us?** | **Marital Status:** |

**Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as patient)**

|  |  |
| --- | --- |
| **Responsible Party:** | **Home Phone:** |
| **Street Address:**  | **Work Phone:** |
| **City, State, Zip Code:** | **Mobile Phone:** |
| **Relationship to Patient:** | **Responsible Party SSN:** |

All donations go to a benevolent fund to help the less fortunate in our community

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

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