NEW PATIENT REGISTRATION

Last Name of Patient______________________________ **First Name**____________________________ **Middle Initial** ___________

Address____**City**_________________ **State**________ **Zip**_______-_________

Home Telephone_(______)____________________**Cell**_(______)______________________**Work**_(______)_____________________

Date of Birth________________________________ **Email**____

Marital Status: **Married** **Single** **Divorced** **Widowed** **Other**

Responsible Party and Relationship to Patient____

Responsible Party Address and Phone Numbers____

Patient's Employer______________________________________ **Address** ____

Occupation ____**Type of Business**____

How were you referred____

In case of an emergency, who may we contact:

Name_________________________________ **Relationship** __________________________ **Phone** ____________________________

Information Pertaining to Spouse, Partner, or Other:

Spouse/Partner Last Name_____________________________**First Name**______________________________ **Middle Initial**______

Address ____**City** ____________________ **State** _______ **Zip** ________-_________

Home Telephone _(____)___________________**Cell** _(____)________________________**Work** _(____)_______________________

Date of Birth_____________________________ **Email**____

Relationship to the Patient:____

Spouse/Partner's Employer's Name and Occupation____

Treatment Plan (to be completed with therapist):

____

____

Payment for services is due at the time of your session(s).

I/We consent to consultation and/or treatment

X____ **X**____

SIGNATURE OF PATIENT, PARENT, OR RESPONSIBLE PARTY — TODAY'S DATE — SIGNATURE OF SPOUSE — TODAY'S DATE

PRIVACY PRACTICES ACKNOWLEDGEMENT: I have received the Notice of Privacy Practices (Psychotherapists-Patient Services Agreement) and have been provided an opportunity to read and review it.

X____**X**____

SIGNATURE OF PATIENT, PARENT, OR RESPONSIBLE PART — TODAY'S DATE — SIGNATURE OF SPOUSE — TODAY'S DATE