REGISTRATION FORM

Please print legibly (circle answers or fill in blanks).

Patient: ____
Last First Middle Initial

Address: ____

City, State, Zip: ____

Home: (____)______________ Work: (____)__________

Cell Phone: (_____) ________________________________

Best # to leave a confidential voicemail: Home Work Cell

Email Address____

Patient Occupation: ________________________________

Name of Employer: ________________________________

Date of Birth: ____________________ Age: ___________

Sex: M F Social Security #: ______________________

Marital Status:
Single Married Separated Widowed Divorced

Education Level: ____________________ # of years______

Dominant Hand: Right / Left / Ambidextrous

Reason for Appointment: ___________________________

____

Emergency Contact: ______________________________
First Last

Relation: Parent Guardian Spouse Other: ____________

Home: (____)____________ Work #: (____)__________

Emergency Contact: #2: ___________________________
(In case of minor, both parents must be listed.)

Relation: Parent Guardian Spouse Other: ____________

Home: (____)____________ Work #: (____)__________

For Minors: Name(s) of Custodial Parent(s)/Guardian(s):

____

Address to send Statements (If different from above):

____

____

Chose MindTherapy Clinic because/Referred by:

__ Website __ Yellow Pages __ Family __ Friend

__ Other (Describe) ________________________________

__ Other Family member treated here:______________

__Referred By Physician:__________________________

__Referred By Therapist:__________________________

Primary Care Physician / Other Doctors / Therapist / Pharmacy

1) **Primary MD Name:** ___________________________

Clinic Name: ____

Street: ____

City, State, Zip: ________________________________

Office #: (____)____________ Fax #: (____)___________

I authorize MTC to communicate with my Primary Physician (if applicable) regarding my care__________
(initial)

2) **Other MD Name:**________________________________

Clinic Name: ____

Street: ____

City, State, Zip: ________________________________

Office #: (____)____________Fax # (____)___________

I authorize MTC to communicate with my Physician (if applicable) regarding my care__________
(initial)

3) **Therapist Name (if applicable)** _____________________

Clinic Name: ____

Street: ____

City, State, Zip: ________________________________

Office #: (____)____________Fax #: (____)___________

I authorize MTC to communicate with my Therapist (if applicable) regarding my care__________
(initial)

4) **Pharmacy (required):**____________________________

Address:____

City, State, Zip: ________________________________

Phone #: (____)____________ Fax #:(____)___________