PATIENT REGISTRATION INFORMATION
Please Print Clearly

Date___________________________ Dr. _____________________________

Last Name_________________________________First Name_______________________MI____

Birthdate______________________________________Age__________Sex_______M_______F

Soc. Sec. #_______________-_______-____________Marital Status_________________________

Address_________________________________City___________________State______Zip______

Phone Numbers:

Home_________________________ Cell_________________________

***Preferred Contact Number _________________________________

Employer Name_______________________________________Occupation___________________

Employer Address____________________________________Employer Phone________________

Who Referred You? _____________________________________Phone______________________

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Please sign here to authorize your doctor to contact the person who referred you

Primary Care MD __________________________Phone________________Fax_______________

Other Therapist____________________________Phone__________________Fax______________

Pharmacy Name___________________________Phone __________________Fax______________

Mail Order Pharmacy Name____

Permission to contact primary care MD/other therapist______________
Initial

Insurance Information (for prior authorization)

Primary Insurance_______________________________________ID#________________________

Secondary Insurance____________________________________ID#________________________

In case of emergency, whom should we contact?

Name____Relationship______________________

Phone: Home_________________________ Work___________________Cell__________________