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| **NEW PATIENT REGISTRATION** |

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| **GENERAL INFORMATION** |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_ Identified Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pronouns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School and Grade and/or Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **MEDICAL AND REFERRAL INFORMATION** |

Complete Name of Primary Care Provider:

Primary Care Provider’s Telephone Number:

Name of Referring Provider and Phone Number:

Name of Pharmacy: Phone: Fax:

**If patient is under 21 years of age, please complete the following information not already included above:**

If parents are Separate/Divorced, what are the custody arrangements:

**Parent #1 Name**: DOB: Policy Holder: Yes  No 

Address:

Home Telephone: May we leave a message? Yes  No 

Cellular Telephone: May we leave a message? Yes  No 

E-mail Address: May we send a message? Yes  No 

**Parent #2 Name**: DOB: Policy Holder: Yes  No 

Address:

Home Telephone: May we leave a message? Yes  No 

Cellular Telephone: May we leave a message? Yes  No 

E-mail Address: May we send a message? Yes  No 

**Collaborative Counseling Center provides appointment reminders via phone, email and/or text message. Please let us know how to communicate your reminders. Check all that apply:**

Home Phone Cell Phone Text Message Email