COLLABORATIVE COUNSELING CENTER
Working together to inspire change and promote growth

5560 Sterrett Place Suite 201
Columbia, MD 21046
T (443) 546-4000 **F** (443) 546-4005
www.CollaborativeCounselingCenter.com

NEW PATIENT REGISTRATION

GENERAL INFORMATION

Name: _____DOB:_____ Identified Gender: _____

Preferred Pronouns:_____ School and Grade and/or Employer: _____

Mailing Address: _____

_____ Phone Number: _____

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 ☐