



# COLLABORATIVE COUNSELING CENTER

Working together to inspire change and promote growth

[www.collaborativecounselingcenter.com](http://www.collaborativecounselingcenter.com)

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## New Patient Registration

### General Information

Patient Name: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Identified Gender: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

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

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

### Medical and Referral Information

Complete Name of Primary Care Provider/Pediatrician: \_\_\_\_\_

Primary Care Provider's Telephone Number: \_\_\_\_\_

Name of Referring Provider and Phone Number: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_

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

Pharmacy Address: \_\_\_\_\_

### Appointment Reminders:

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:\*

For your appointment reminders, which phone number/email would you like us to use? \*

\_\_\_\_\_

### Emergency Contact:

In the case of an emergency, if we are not able to get in contact with the parent/guardian, please include an emergency contact:

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Relationship to Patient: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Emergency Contact Email: \_\_\_\_\_