COLLABORATIVE COUNSELING CENTER
Working together to inspire change and promote growth

5560 Sterrett Place, Suite 201
Columbia, MD, 21044
p. (443) 546-4000
f. (443) 546-4005

www.collaborativecounselingcenter.com

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: _____

Parent/Guardian Information:

Parent/Guardian 1

Name: _____

Date of Birth: _____

Insurance Policy Holder: Yes No

Telephone Number: _____

Email Address: _____

Address: _____

_____

Parent/Guardian 2
If applicable

Name: _____

Date of Birth: _____

Insurance Policy Holder: Yes No

Telephone Number: _____

Email Address: _____

Address: _____

_____

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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: _____