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## REGISTRATION FORM

### Section I: Patient Information

Date \_\_\_\_\_

Name: \_\_\_\_\_ I Prefer to be called: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

The best time to contact me is: \_\_\_\_\_  A.M.  P.M. on my  Home phone  Work phone  Cell phone

\*May I leave a confidential voice message? \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Widowed  Separated  Divorced

If Student, Name of School \_\_\_\_\_ City/State \_\_\_\_\_  FT

PT  
Spouse or Parent's Name: \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may I thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

Your Email Address \_\_\_\_\_

### Section II Responsible Party

Relationship to Patient:  Self  Spouse  Parent  Other

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

By printing and signing my name below, I agree to take responsibility for all fees associated with above client's care.

Printed Full Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_