# **Registration Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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|  |  |
| --- | --- |
| Today’s Date: | Psychologist: Dr. Brian S. Sedgeley |

PATIENT INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Last name:  |  First:  | Middle:  | Marital status:  |

|  |  |  |  |
| --- | --- | --- | --- |
| Is this your legal name? | If not, what is your legal name? | Birth date: | Gender: |
|  |  |

Full Address: [Address/ P.O Box, City, ST ZIP Code]

|  |  |  |
| --- | --- | --- |
| Social Security no.: | Home phone no.: | Cell phone no.: |
|  |  |  |
| Would you like to receive appointment reminders? (additional $5/month) | Employer: | Email address.: |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Chose clinic because/referred to clinic by: |  |  |
|  |  |  |
| Current medications (dosages and prescribing reason): |

Monthly Income: BILLING INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Person responsible for bill: | Birth date: | Address (if different): | Home phone no.: |
|  |  |  |
| Relationship to patient: |  | Email address: | Cell phone no.: |
| Occupation: | Employer: | Employer address: | Employer phone no.: |
|  |  |  |  |

IN CASE OF EMERGENCY

|  |  |  |  |
| --- | --- | --- | --- |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: | Cell phone no.: |
|  |  |  |  |

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Brian S. Sedgeley, Psy.D. to release any information required to process my billing/invoicing.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
|  | Patient/Guardian signature |  | Date |  |

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