# **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 |  | |