CLOCKTOWER
PSYCHOLOGICAL ASSOCIATES, LTD

Registration Form

Patient Name _____ Today's Date ____/____/____

Address _____ Home Phone (____) _____ - _____
OK to call? □ Yes □ No OK to leave message? □ Yes □ No

City _____ State _____ Cell Phone (____) _____ - _____
OK to call? □ Yes □ No OK to leave message? □ Yes □ No

Zip _____ Work Phone (____) _____ - _____
OK to call? □ Yes □ No OK to leave message? □ Yes □ No

Sex: M ____ F ____ Student: F/T ____ P/T ____ Date of Birth ____/____/____ Age ____

□ Single □ Married □ Partnered
Spouse's/Partner's Name _____ E-mail Address _____

If Patient is a Minor **(under the age of 18)**

Parent/Guardian Name _____ Home Phone (____) _____ - _____
OK to call? □ Yes □ No OK to leave message? □ Yes □

Parent/Guardian Name _____ Home Phone (____) _____ - _____
OK to call? □ Yes □ No OK to leave message? □ Yes □

Is there a formal custody arrangement with regard to this minor/client? □ Yes □ No
Are both parents aware that this child is receiving treatment? □ Yes □ No
Do both parents consent to this child receiving treatment? □ Yes □ No

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Name of Individual Responsible for Billing _____

Address _____ City _____ State _____ Zip _____
(if different from above)

Emergency Information

In Case of an emergency, notify _____

Relationship _____ Phone (____) _____ - _____

Family Physician _____ Physician's Phone (____) _____ - _____

Whom may we thank for referring you to us _____ Phone (____) _____ - _____

Office Use Only Provider _____ Diagnosis _____