

POTOMAC PSYCHIATRY REGISTRATION FORM

(Please Print)

Today's date:			Primary Care Physician (Name)/ phone number:			
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Dr. <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date: / /	Age: Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone number: ()	
					Mobile phone number: ()	
P.O. box:		City:			State:	ZIP Code:
Occupation:		Employer:			Employer phone number: ()	
Referred by	<input type="checkbox"/> Doctor (name):	<input type="checkbox"/> Friend (name):	<input type="checkbox"/> Internet search term:		<input type="checkbox"/> Other:	
What was the main reason why you chose our practice?					Email address:	

FINANCIAL INFORMATION			
Person responsible for payment:	Birth date: / /	Address (if different):	Home phone number: ()
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Occupation:	Employer:	Employer address:	Employer phone number: ()
Spouse's Full Name:			

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone number: ()	Work phone number:
		Mobile phone number: ()	()

The above information is true to the best of my knowledge. I understand that I am responsible for payment and that payment is required at the time Services are rendered.

Patient/Guardian signature

Date