Amy B Rosenberg, PsyD, PLLC

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS:

NAME (LAST, FIRST): _____ DATE OF BIRTH: _____ SEX (circle): M | F
ADDRESS_____CITY _____ STATE _____ZIP _____
PHONE # (Home):_____ PHONE# (Daytime): _____ PHONE# (Cell): _____
EMAIL: _____ SOCIAL SECURITY #_____

The following questions are optional and you can choose to decline – [ ] DECLINE **WHAT RACE/ETHNICITY DO YOU SELF IDENTIFY AS? WHAT IS YOUR PREFERRED LANGUAGE?**
***RACE** (circle): AMERICAN INDIAN/ALASKAN NATIVE | ASIAN | BLACK /AFRICAN AMERICAN | NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER | WHITE OTHER **:**
***ETHNICITY** (circle): HISPANIC | NON-HISPANIC
***** **PREFERRED LANGUAGE** (circle): ENGLISH | SPANISH | OTHER:

PRIMARY CARE PHYSICIAN (PCP):

NAME: _____ PHONE#_____ FAX# _____
ADDRESS_____CITY _____ STATE _____ZIP _____

RESPONSIBLE PARTY INFORMATION (circle) SELF | SPOUSE | CHILD | PARENT | STUDENT | OTHER | **IF NOT SELF, COMPLETE FIELDS BELOW;**

NAME (Last, First)_____PHONE # _____
ADDRESS_____CITY _____ STATE _____ZIP _____

EMERGENCY CONTACT

NAME (Last, First)_____PHONE # _____
ADDRESS_____CITY _____ STATE _____ZIP _____

HOW WERE YOU REFERRED TO THIS OFFICE? (circle): SELF | ANOTHER PATIENT |EMPLOYER | OTHER(complete below):
IF REFERRED BY A DOCTOR; PHYSICIAN NAME:_____ PHONE# _____
IF REFERRED BY OTHER, PLEASE EXPLAIN: _____

X _____ _____
PATIENT/PARENT/LEGAL GUARDIAN (or authorized signature) DATE