Patient Registration Form

Demographic Information:

Full Legal Name: _____

Preferred Name / Nickname: _____

Date of Birth: _____

Sex/Gender: _____

Age: _____

Marital Status: _____
(ie – Single, Married, Partnered, Widowed, Divorced, Cohabiting)

How did you learn about Dr. Schroeder? _____
(Friend, Family, Internet [which website?], Primary Care, Therapist, Etc.)

Contact Information:

Address: _____ _____
(Street Address) *(City)* *(State)* *(Zip)*

Phone Numbers:	Preferred?	Day or Evening?	Privacy Concerns?
Home: _____			
Cell: _____			
Work: _____			
Other: _____			

Emergency Contact:

Name: _____

Address: _____

Relationship: _____

Phone Number(s): _____

_____

(Will <u>not</u> be contacted except in emergency unless you instruct us otherwise.)

Medical History:

List Any Known Medical Problems: _____

List Any Known Allergies: _____

List All Medications You Are Taking: _____

(SIGNATURE) (DATE)