Patient Registration Form

Personal Information

Today's Date

Email

Legal First Name

Legal Last Name

Preferred Full Name (if different from above)

Preferred Pronoun

Cell Phone

Work Phone

Home (landline) Phone

Date Of Birth

Sex Assigned At Birth

Address

Address Line 1

City

State

Zip Code

Permission to Send Email?

- [ ] Yes
- [ ] No

Sexual Orientation

- [ ] Straight or Heterosexual
- [ ] Gay, Lesbian or Homosexual
- [ ] Bisexual
- [ ] Not Sure
- [ ] Prefer Not To Say
- [ ] Other

Gender Identity

- [ ] Female
- [ ] Male
- [ ] Transgender Female
- [ ] Transgender Male
- [ ] Genderqueer
- [ ] Prefer Not To Say
- [ ] Other

Race

- [ ] American Indian / Alaska Native
- [ ] Asian
- [ ] Hawaiian / Pacific Islander
- [ ] Black / African American
- [ ] Caucasian
- [ ] Hispanic
- [ ] Prefer Not To Say
- [ ] Other

Ethnicity

- [ ] Hispanic / Latino
- [ ] Not Hispanic / Latino
- [ ] Prefer Not To Say

Preferred Language

- [ ] English
- [ ] Spanish
- [ ] ASL
- [ ] Mandarin
- [ ] Tagalog
- [ ] Arabic
- [ ] Other

Responsible Party Information (if not self)

Responsible party

- [ ] A Different Patient
- [ ] Guarantor
- [ ] Self

Responsible Party First Name

Responsible Party Last Name

Responsible Party Phone

Responsible Party Social Security Number

Date Of Birth

Sex At Birth

- ○ Female
- ○ Male
- ○ Prefer Not To Say

Responsible Party Address

Address Line 1

City

State

Zip Code

Emergency Contact Information

Emergency Party First Name

Emergency Party Last Name

Emergency Cell Phone

Emergency Work Phone

Emergency Home (landline) Phone

Relation To Patient

Do you have a living will

- ○ Yes
- ○ No

Emergency Contact Address

Address Line 1

City

State

Zip Code

General Consent For Care And Treatment

As a client, you have the right to be informed about your condition and any recommended therapeutic, psychological, or diagnostic procedures. This knowledge allows you to make an informed decision about whether to proceed with the suggested course of action, understanding the associated risks and benefits. At this stage, no specific treatment plan has been proposed. This form is to obtain your consent for the evaluations necessary to determine the appropriate treatment and/or procedures for any identified conditions.

Consent for Therapeutic Evaluations

By signing this form, you grant us permission to conduct reasonable and necessary assessments, tests, and treatments. Specifically, your signature indicates that:

1. This consent is ongoing, even after a diagnosis has been made and treatment recommended.
2. You agree to receive treatment at this office or any affiliated satellite office under common ownership.

This consent remains valid until you revoke it in writing. You reserve the right to discontinue services at any time.

Discussion of Treatment Plan

You have the opportunity to discuss any treatment plan with your counselor, therapist, or psychiatrist, including the purpose, potential risks, and benefits of any tests or treatments recommended. If you have concerns or questions about any suggestions made by your

mental health provider, we encourage you to ask for clarification.

Request for Mental Health Services

I voluntarily request that a counselor, therapist, psychiatrist, or any other relevant mental health professional, conduct reasonable and necessary assessments, tests, and treatments for the condition for which I am seeking care at this practice. I understand that if additional assessments, invasive procedures, or specialized interventions are recommended, I will be asked to read and sign additional consent forms before proceeding with these actions.

Signature Of Patient Or Representative

Todays Date

Signature Of Patient Or Representative

Relation To Patient