COLLABORATIVE COUNSELING TMS

Map Your Journey • Activate Your Brain • Restore Your Hope.

New Patient Registration

General Information

Name: _____ DOB: _____ Sex: _____

Mailing Address: _____

City, State, ZIP: _____

SSN: _____ School/Employer: _____ Grade: _____

Medical and Referral Information

Complete Name of Primary Care Provider: _____

Primary Care Provider's Telephone Number: _____

Name of Referring Provider and Phone Number: _____

Name of Pharmacy: _____ Phone: _____ Fax: _____

If patient is under 21 years of age, please complete the following information not already included above:

If parents are Separate/Divorced, what are the custody arrangements:

Parent #1 Name _____ DOB: _____ Policy Holder: Yes ☐ No ☐

Address: _____

Home Telephone: _____ May we leave a message? Yes ☐ No ☐

Cellular Telephone: _____ May we leave a message? Yes ☐ No ☐

E-mail Address: _____ May we send a message? Yes ☐ No ☐

Parent #2 Name: _____ DOB: _____ Policy Holder: Yes ☐ No ☐

Address: _____

Home Telephone: _____ May we leave a message? Yes ☐ No ☐

Cellular Telephone: _____ May we leave a message? Yes ☐ No ☐

E-mail Address: _____ May we send a message? Yes ☐ No ☐

Collaborative Counseling TMS provides appointment reminders via phone, email and/or text message. Please let us know how to communicate your reminders. Check all that apply:

Home Phone	Cell Phone	Text Message	Email
☐	☐	☐	☐