2126 Espey Ct, Ste C
Crofton, MD 21114
410-451-3000 (phone)
667-295-7336 (fax)

NEW PATIENT ADOLESCENT REGISTRATION FORM

Today's Date: ______________ Referral Source: ________________________________

Patient Information

Patient Full Name: ____

Date of Birth: ________________________ Gender: ☐ Male ☐ Female

Home Address: ____

City/State/Zipcode:____

Preferred Phone Number: Mobile/Home ____

Alternative Phone Number: Mobile/Home ____

E-mail: ____

Person Financially Responsible for this Patient

Full Name: ____

Address (if different than above): ____

Contact Phone Number: Mobile/Home ____

****Please be aware that important appointment reminders & practice announcements are sent by email and/or text so it is important to have your best email address and mobile number for this purpose.**

Emergency Contact (in case of a medical or psychiatric emergency)

Name: _____________________________________ Relationship: ______________________

Phone: _____________________________

Therapist or Counselor: _________________________________ Phone: _____________________

Primary Care Provider (PCP): _____________________________ Phone: ___________________

Other Providers: (Include specialists and/or complementary health providers who are important to your care)

____

____

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Medical Insurance Carrier

(Although we do not accept insurance, we may need this information for prescription or laboratory purposes.)

Name of Plan: ____

Policy #: ___________________ Group #: _______________

Name of Policyholder: _____________________________ Policyholder's Date of Birth: ____________

Birth history: ____

Marital status of parents: ____

Developmental history: ____
____
____
____

Who lives in the house (list all members with ages): ____
____

School issues/current grades: ____
____
____

Hobbies: ____

Access to firearms? ____

Risk-taking behavior (sneaking out, marijuana, sexual activity): ________________________________
____

History of trauma: ____
____

Age of first period: _______________