ROBERT H. SPIRO, Ph.D., ABPP
PATIENT REGISTRATION

Patient information

First Name:_____ Middle Name: _____ Last Name: _____

Street Address:_____ City:_____ State:_____ Zip:_____

Email: _____ Date of Birth:_____ Gender/Pronoun:_____

Marital Status: Married:_____ Single:_____ Divorced:_____ Partnered:_____ Widowed:_____

Home Phone:_____ Cell Phone:_____ Work Phone and Ext:_____

What is your preferred method of contact: Home Phone:_____ Cell Phone:_____ Work Phone:_____

Emergency Contact:_____ Phone:_____ Relationship to Patient:_____

Primary Care Physician: _____ Phone:_____ Fax: _____

Address:_____

How did you hear about us?_____

Financially Responsible Party

First Name:_____ MI:_____ Last Name:_____

Email:_____ Date of Birth_____ Phone:_____

Relationship of Financial Party to Patient: Self:☐ Spouse:☐ Parent:☐ Guardian:☐ Other:☐

Address (if different from Patient) _____

I understand that I am financially responsible for services rendered a that this Practice. I understand that I am responsible to pay the entire balance. Please refer to the Practice Policy Consent for additional financial policies.

If **Patient is a Minor:** By signing below, as parent, legal guardian, or authorized party, I consent and authorized on behalf of the Patient, to rendering of care, treatment and payment.

By signing below, 1 acknowledge that the information provided is accurate
and I ***agree to the terms set forth above.***

Signature of Patient or Legal Guardian:_____ Date:_____

Print Name of person signing;_____ Relationship to the patient:_____

Signature of Patient (Couple therapy only) _____ Date:_____

Print Name of person signing;_____ Relationship to the patient:_____