

# Central Texas Mental Health

## Patient Demographics and Registration

### Please Print Legibly:

Patient's Name \_\_\_\_\_

Male  Female Date of Birth (month/day/year) \_\_\_\_\_

Marital Status  Single  Married  Widowed  Divorced  Other \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License \_\_\_\_\_ State \_\_\_\_\_

Home Tel. # ( ) \_\_\_\_\_ Cell # ( ) \_\_\_\_\_ Work # ( ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Apt # \_\_\_\_\_ ( NA) City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physical Address

Same as mailing address Email \_\_\_\_\_

Other:

Physical Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_

Employer Address \_\_\_\_\_

Referred by \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

Primary Care Doctor's Telephone # if known \_\_\_\_\_

Primary Emergency Contact Name \_\_\_\_\_ Tel # \_\_\_\_\_

Secondary Emergency Contact Name \_\_\_\_\_ Tel # \_\_\_\_\_

**Treatment Authorization:** I authorize Dr. Michael Musgrove and his representatives to provide me with medical care and services. **Initials:** \_\_\_\_\_

**Medical Information:** I authorize Dr. Michael Musgrove and his representatives to release any and all information acquired during treatment to other treatment facilities and providers to whom I am under care on an emergent basis, or to persons or entities directly responsible for payment of services (if applicable). I further authorize Dr. Musgrove and his representatives to access electronic prescription history databases for the purpose of my medical care and safety. **Initials:** \_\_\_\_\_

**Payment agreement:** I agree I am financially responsible for the payment fee(s) for service even though insurers may or may not reimburse me. **Initials:** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Occupation: \_\_\_\_\_

Education Level: \_\_\_\_\_

Have you had previous psychiatric treatment?  Yes  No

If yes, where 1. \_\_\_\_\_ When \_\_\_\_\_

2. \_\_\_\_\_ When \_\_\_\_\_

3. \_\_\_\_\_ When \_\_\_\_\_

Additional: \_\_\_\_\_

Have you had previous chemical dependency treatment (detox, etc.)  Yes  No

1. \_\_\_\_\_ When \_\_\_\_\_

2. \_\_\_\_\_ When \_\_\_\_\_

3. \_\_\_\_\_ When \_\_\_\_\_

Additional: \_\_\_\_\_

Current Psychiatrist \_\_\_\_\_ How long \_\_\_\_\_ Last seen \_\_\_\_\_

Current Therapist \_\_\_\_\_ How long \_\_\_\_\_ Last seen \_\_\_\_\_

Current Primary Doctor \_\_\_\_\_ How long \_\_\_\_\_ Last seen \_\_\_\_\_

Last Physical Examination \_\_\_\_\_ What reason? \_\_\_\_\_

Why are you seeking help today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Who do you live with?

Name	Relationship	Age
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Religion (OPTIONAL): \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_