Central Texas Mental Health

Patient Demographics and Registration *(please print legibly)*

Name (Last, First) ____

○Male ○Female ○Other(*describe*) ________________Date of Birth(MM/DD/YYYY)_____/____/_____

Marital Status: ○ Single ○ Married ○ Widowed ○ Divorced ○ Other (*describe*) __________________

Social Security # _______-_______-________ Driver's License # _______________________State__________

Cell (   )__________________ Home(   )___________________Work (   )_________________

Mailing Address: ____

Apt # _____________ City _______________________________ State ____________ Zip ______________

Email ____

Physical Address (*if different from mailing address*)

Street____

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

____

____

____

Religion (OPTIONAL): ____

Race (OPTIONAL): ____

Orientation (OPTIONAL): □ Straight □ Gay/Lesbian □ Bisexual □ Other - Describe __________________

Patient's Signature ____

Patient's Name ____ Date ______________________