3040 N. University Ave. Suite 2
Decatur, IL 62526
phone: 217.872.1700
fax: 217.872.1366
www.decaturpsych.com

**REGISTRATION**

Today's Date ____ / _____ / ______

**Patient Information**

Name: ______________________________________________ Preferred name: ______________________

Address: _____________________________City: ___________________ST: ______ Zip Code: ___________

Date of Birth __ __ / __ __ / __ __ __ __ Social Security Number __ __ __ - __ __ - __ __ __ __

Phones: Home:_____________________ Cell:_________________________ Work:____________________

Appointment reminder calls? (Circle one) **Home** **Work** **Cell** **Email** **No Calls**

Email address:________________________________________________________________________

**If Employed:**

Name of Employer: _____________________________________ Occupation: ________________

**If Patient is under the age of 18 who is the legal guardian?**

Name: ______________________________ Relationship: _______________________________

Address: __________________________________ ST: ______________ Zip Code: __________

Home Phone: ______________________ Cell Phone: _________________ Work: ______________

Date of Birth __ __ / __ __ / __ __ __ Social Security Number __ __ __ - __ __ - __ __ __ __

**Additional Information:**

Primary Care Physician __________________ Address _________________ Phone ____ _____ - ______

**May we contact your Physician if necessary? (Circle one) Yes No Initial** _______

Please list all medications that you are currently taking:

| | |
|---|---|
| | |
| | |
| | |
| | |

Please list any allergies:

| |
|---|
| |
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| |

11/9/2016