BROWARD PSYCHOLOGICAL ASSOCIATES
NEW PATIENT REGISTRATION

NAME_____

HOME PHONE_____
WORK PHONE_____
AGE_____ DATE OF BIRTH_____ CELL PHONE_____

HOME ADDRESS_____CITY_____STATE_____ZIP_____

EMERGENCY CONTACT_____
PHONE_____
EMAIL ADDRESS_____ _____

EMPLOYER_____

OCCUPATION_____

If patient is under the age of 18, please ALSO complete the following:

Father's name:_____ Phone number:_____
Lives with the client: _____ Full time _____ Part time

Mother's name:_____Phone number_____
Lives with the client: _____Full time _____ Part time

REFERRED BY_____

PRESENTING PROBLEM(S)_____

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

**24 HOUR NOTICE OF CANCELLATION OF AN APPOINTMENT IS REQUIRED OR THE PATIENT WILL BE RESPONSIBLE FOR A $50.00 FEE.

Signed _____ Date _____

Printed name:_____ Relationship to client:_____