PATIENT REGISTRATION

Mountainview Clinical Psychology, PLLC
14300 N. Northsight Blvd. #215
Scottsdale, AZ 85260
141 S. McCormick St. #109
Prescott, AZ 85360

Today's Date: ___________________________

Name:____**Date of Birth**:___________________

Gender: M F Other _______ **Age:**________ **Handedness:** [ ] right [ ] left [ ] ambidextrous

---

Address:____

____

State_______________ **Zip**_________________________

Primary Phone:____

Secondary Phone: ____

E-MAIL:____

Marital Status: [ ]Single [ ]Separated [ ]Divorced [ ]Married [ ]Partner [ ]Widowed

Primary Language:_______________________________________**Religion**:______________________

Race (Circle all that apply): Hispanic Black/African American Asian Caucasian

American Indian Alaska Native Native Hawaiian Pacific Islander Other_____________

Highest Education Years Completed____________ **Degree(s)**:_______________________________

Were you ever diagnosed with a **learning disability or attention deficit disorder?** Y/N

Do you suspect you have an **undiagnosed learning or attention problem?** Y/N

What concerns are you hoping to address with this evaluation?

____

____

Are you represented by an attorney for injuries related to the purpose of this evaluation? [ ] **NO [ ] YES [ ]**
Attorney Name____

Have you had a **prior neuropsychological evaluation**? [ ] YES [ ] NO

Employment Status (circle one): Full-time Part-time Retired Disabled Student

If employed:
EMPLOYER'S NAME____

OCCUPATION____

Emergency Contact Name:____

Relationship to patient:____

Phone #:____ email: _____________________________________

Address:____

City____State: ______________ zip: ________________________

PRIMARY INSURANCE INFORMATION INSURANCE **********************************

COMPANY_______________________POLICY#________________________Group #_____________

ADDRESS____CITY______________STATE__________

ZIP CODE_____________________PHONE #____________________

SECONDARY INSURANCE INFORMATION
INSURANCE COMPANY_____________POLICY#_________________________GROUP#___________

ADDRESS____CITY______________STATE__________

ZIP CODE_____________________PHONE #____________________

IF PATIENT IS OTHER THAN THE INSURED, PLEASE COMPLETE THIS SECTION INSURED'S

NAME__________________________ RELATIONSHIP TO PATIENT____________________

INSURED'S DATE OF BIRTH______________________

INSURED'S EMPLOYER ADDRESS____

PHONE # ____

Other Doctors who should receive a copy of the report for today's visit: other you're your referring doctor (a release of information will need to be completed for each provider):** After identifying other provider you would like your report sent to, we will provide you with Release of Information forms for each provider to sign in order for us to release that information.**

____

Do you have a medical or legal PoA? [ ] YES [ ] NO

If Yes, name of your PoA: ____

Please provide Dr. Husk with a copy of your PoA paperwork.