PATIENT REGISTRATION

Mountainview Clinical Psychology, PLLC
14300 N. Northsight Blvd. #215, Scottsdale, AZ 85260

Date: _____

Name:_____Date of Birth:_____

Gender: M F Other _____ Handedness: [ ] right [ ] left [ ] ambidextrous

Address:_____City_____

State_____Zip_____ Primary Phone:_____

Secondary Phone:_____ E-MAIL_____

Marital Status: [ ]Single [ ]Separated [ ]Divorced [ ]Married [ ]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 regarding 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 #:_____Address:_____

City_____State: _____

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):

_____

_____

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.