PATIENT REGISTRATION

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

Today's Date: _____

Name:_____**Date of Birth**:_____

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

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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 than 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/Dr. Mahan with a copy of your PoA paperwork.