Nevada
Center for Behavior Therapy

Licensed in Nevada and New York

PATIENT REGISTRATION FORM

Date: _____

Patient's Legal Name_____

Address: _____

City: _____ **State** _____**Zip**_____

Patient's SS#: _____ **Sex**: M F **Date of Birth**: ____/___/____

Home Phone:_____ **Cell Phone**:_____ **E-Mail**: _____

Occupation: _____

For phone calls for treatment follow up, reminders and emergencies, which telephone # do you prefer for us to call you: _____ Best times: _____ (If not, please state NO.)

Referred by / How did you find us? _____

Have you had previous treatment? Yes No

If yes, when?_____ **Who?** _____

Family Physician: _____

Current Medication(s):_____

Notify in emergency: _____

Relationship: _____

Home#:_____ **Work#**:_____