

Site _____

Dr. _____

Gersten Center for Behavioral Health
TAP-IN REGISTRATION FORM

Patient Information

Name First _____ Initial _____ Last _____ Sex _____ Marital Status _____
Social Security No. _____ - _____ - _____ D/O/B ____/____/____ Who referred you _____
Street Address _____ Apt. No. _____
City _____ State _____ Zip _____ Home Phone () _____ - _____
Cell Phone () _____ - _____ Business Phone () _____ - _____ Email Address _____
Currently Employed YES () NO () Full Time Student YES () NO () Part Time Student YES () NO ()

Employer Information

Employer Name _____ Employer Phone () _____ - _____
Street Address _____ City _____ State _____ Zip _____
Who referred you to TAP-IN? _____

Emergency Contact

Name _____ Relationship _____
Home Phone () _____ - _____ Cell Phone () _____ - _____ Business Phone () _____ - _____
Physician Name _____ Phone () _____ - _____ Fax () _____ - _____

CONSENT FOR TREATMENT: I authorize the psychologist to administer treatment as deemed necessary or advisable by the psychologist.

Signature

Date

Relationship

Witness