Central Texas Mental Health

Patient Demographics and Registration

Please Print Legibly:

Patient's Name ____

□ Male □ Female □ Other - Describe _______________ Date of Birth (month/day/year) ____________

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Other - Describe ____________________

Social Security # ___________________ Driver's License _________________ State _____________

Home Tel. # ( )________________ Cell # ( )_______________ Work # ( )_______________

Mailing Address: ____

Apt # __________(□ NA) City _____________________ State _______________ Zip _____________

Physical Address

□ Same as mailing address Email ____________________________

□ Other:

Physical Address: ____

City ________________________ State ______________________ Zip ______________________

Employer ____

Employer Address ____

Referred by ____

Primary Care Doctor ____

Primary Care Doctor's Telephone # if known ____

Primary Emergency Contact Name ________________________________ Tel # ___________________

Secondary Emergency Contact Name ______________________________ Tel # ___________________

Treatment Authorization: I authorize Dr. Michael Musgrove and his representatives to provide me with medical care and services**. Initials:** __________

Medical Information: I authorize Dr. Michael Musgrove and his representatives to release any and all information acquired during treatment to other treatment facilities and providers to whom I am under care on an emergent basis, or to persons or entities directly responsible for payment of services (if applicable). I further authorize Dr. Musgrove and his representatives to access electronic prescription history databases for the purpose of my medical care and safety. **Initials:** ________

Payment agreement: I agree I am financially responsible for the payment fee(s) for service even though insurers may or may not reimburse me. **Initials:** ________

Patient Signature: ______________________________________ Date: _________________________

Printed Name: ____

Occupation:____

Education Level:____

Have you had previous psychiatric treatment? □ Yes □ No

If yes, where 1. ____ When ___________________

2. ____ When ___________________

3. ____ When ___________________

Additional: ____

Have you had previous chemical dependency treatment (detox, etc.) □ Yes □No

1. ____ When ___________________

2. ____ When ___________________

3. ____ When ___________________

Additional: ____

Current Psychiatrist ____________________________ How long ________ Last seen _____________

Current Therapist ______________________________ How long ________ Last seen _____________

Current Primary Doctor __________________________ How long ________ Last seen _____________

Last Physical Examination ________________________ What reason? __________________________

Why are you seeking help today? ____

____

____

Who do you live with?

Name Relationship Age

____

____

____

Religion (OPTIONAL): ____

Race (OPTIONAL): ____

Orientation (OPTIONAL): □ Straight □ Gay/Lesbian □ Bisexual □ Other - Describe _________________

Patient's Signature ____

Patient's Name ____ Date _____________________