Adult ADHD and Anxiety Clinic

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E-mail: Office@AdultADHDandAnxietyClinic.com

Registration Information

(Please print)

Date: ____/____/_____

Client Name: (Last, First, Middle) _____

Date of Birth: ____/____/_____ Age:_____ Sex: Male ☐ Female ☐ SSN: _____/____/_____

Main Phone: (_____)_____-_____ Is it Home ☐ Work ☐ or Cell ☐ ?

Can we leave a message? Yes ☐ No ☐ Can we text you? Yes ☐ No ☐

Client E-mail: _____

Client Address: _____

Employer: (Name, Address, Phone) _____

Emergency Contact _____ Phone (____)____-_____

Primary Doctor**:** (Name, City, State) _____ Phone (_____)____-_____

Referring Doctor**:** (Name, City, State) _____ Phone (_____)____-_____

Therapist: (Name, City, State) _____ Phone (_____)____-_____

Client Pharmacy**:**
(Name, Address, Phone, Fax): _____

_____

Client Signature: _____ Date: ____/____/_____