Link Psychiatry

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell Phone _____

Business Phone _____ Email Address _____

Please indicate where Dr. Link may leave voice messages. You may check more than one. By checking a box below, you are agreeing to allow Dr. Link to leave voice messages, relating to your mental health care, at that phone number.

☐ Home ☐ Cell ☐ Business

Birthdate _____ Gender ☐ Male ☐ Female ☐ Non-binary
MM/DD/YEAR

Employer _____ Occupation _____

Emergency Contact Information:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Current Providers:

Psychiatry: ☐ No ☐ Yes: Name _____Phone _____

Therapy: ☐ No ☐ Yes: Name _____Phone _____

Primary Care: ☐ No ☐ Yes: Name _____Phone _____

Version: September 2018

Medical History:

Medication Allergies: ☐ No ☐ Yes: _____

Please list your active and/or chronic medical conditions/diagnoses: _____

_____

Please list all current medications, including vitamins and supplements:

Medication Name	Dose (e.g. 2 mg)	Frequency (e.g. twice a day)

Signature _____ Date _____