Link Psychiatry

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Cell Phone _____ Email Address _____

Please indicate if Dr. Link may leave voice messages on the patient's cell phone. By checking a box below, you are agreeing to allow Dr. Link to leave voice messages, relating to your child's mental health care, at that phone number.

☐ Yes ☐ No

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

School _____ School's Phone _____

Current Providers:

Psychiatry: ☐ No Yes: Name _____Phone _____

Therapy: ☐ No Yes: Name _____Phone _____

Primary Care: ☐ No Yes: Name _____Phone _____

Medical History:

Medication Allergies: ☐ No Yes: _____

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

_____

Version: September 2018

Please list all current medications, including vitamins and supplements:

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

Parent/Guardian's Contact Information (PARENT/GUARDIAN #1):

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 child's mental health care, at that phone number.

☐ Home ☐ Cell ☐ Business

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

Employer _____ Occupation _____

Parent/Guardian's Contact Information (PARENT/GUARDIAN #2):
Please feel free to write "Same as above" for any appropriate items

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 child's mental health care, at that phone number.

☐ Home ☐ Cell ☐ Business

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

Employer _____ Occupation _____

Signature _____ Date _____
(Parent/Guardian)