for
Dr. John B.
Lochridge
only

Patient Registration

Today's Date:

Patient's full name: _____ Name called: _____

Age: _____ Date of birth: _____ Sex: _____ Marital status: _____

Parents' name (if minor): _____

Address: _____

_____

Phone numbers - home: _(_____)_____ work: _(_____)_____

cell: _(_____)_____ work: _(_____)_____

Occupation / Employer: _____
(Parents, if patient is minor)

_____

Business address: _____

Guarantor (person responsible for the bill): _____

Billing address (if different): _____

Phone (if different): _____

I was referred by: _____

We request payment at the time of service. You will receive an itemized statement for insurance and/or income tax purposes. Please indicate how you wish to pay.
_____cash _____check _____visa _____mastercard _____discover _____amex

If your teenager will come to appointments alone, you may send
a check or credit card or leave a credit card number on file.

Patient's name: _____

Other family or household members:

Name	Relation	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's physician:_____ Phone: _(_____)_____

Last physical exam: _____ Allergies: _____

Current medications: _____

School (if minor): _____ Grade: _____

Special educational needs: _____

_____

Previous psychotherapy: (therapist, location, and approximate dates)

_____

_____

Psychological testing: (person or agency performing the test, location and date)

_____

_____

Psychiatric hospitalizations: (hospital, location, date)

_____

_____

I give Dr. Lochridge's office permission to confer with the above mentioned therapists(s) or physician(s) about my (my child's) case. I also understand that I will be charged for appointment time if I fail to give 24 hours notice of cancellation.

_____ _____

(signature of patient or parent if patient is a minor) (date)