J. Gary Dolinsky, Ph.D.
Licensed Psychologist Provider

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Patient Registration

TODAY'S DATE: _____

FIRST NAME: _____ LAST NAME: _____ MAIDEN: _____

STREET/APT. #: _____ CITY: _____ STATE: _____ ZIP:____

AGE:_____ DATE OF BIRTH:_____MARITAL STATUS:_____

OCCUPATION/POSITION:_____

EMPLOYER/SCHOOL: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ FAX:_____ EMAIL:_____

EMERGENCY CONTACT PERSON: _____ RELATIONSHIP:_____

HOME PHONE: _____ WORK PHONE: _____ CELL:_____

How did you learn about my practice? _____

REFERRED BY:_____ PHONE:_____ FAX:_____

Primary Care Physician _____

Address_____

PERSON REPONSIBLE FOR BILL (if other than you): _____

ADDRESS: _____

I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand it is my responsibility to pay Dr. Dolinsky's stated fee at the time that services are rendered.

DATE:_____ SIGNATURE:_____