WOODROW WILSON Ph.D.
Clinical Psychology

Miami, Florida
Phone: (305) 342-3425 Fax: (305) 271-7744
Pepwilson@aol.com

PATIENT REGISTRATION FORM

Patient Name ____ Age ____ Birth Date ___________

Address ____ City ___________ Zip ___________

Cell Phone (____) __________________________ Other Phone (____) _____________________

Occupation ________________________________ Soc. Sec. # _____________________________

Patient Status: ☐ Single ☐ Married ☐ Other
☐ Employed ☐ Full Time Student ☐ Part Time Student

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name ____ Birth Date _____________

Insured ID Number ____ Sex: ☐ Male ☐ Female

Insured Policy Group Number __________________ Insured Telephone # (____) __________

Insured Address _______________________________ City ___________ State ____ Zip______

Insured Employer Name or School ____

Insurance Company or Program Name ____

Was Authorization needed? ☐ No ☐ Yes – If Yes, Auth # ______________________________

# of Sessions Authorized _______ Dates: From ______ To ______ Co-Pay Amount? ______

Nature of Current Problem(s) ____

Any Medical Condition? ________________________ Medications? ________________________

Has the Patient ever been in psychological therapy before? ☐ Yes ☐ No

Signature of Patient (at least 18 years old) or legally responsible adult

____ Date __________________________

Thank you.