

# W. Michael Rogers, Psy.D., P.L.L.C.

Clinical Psychologist

drmichaelrogers@rainierconnect.com - www.drmmichaelrogers.com

## NEW PATIENT REGISTRATION

Office Use Only

Dx Code: \_\_\_\_\_

Today's Date: \_\_\_\_\_

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May I call this number? Y N May I leave a message? Y N

Cell Phone: \_\_\_\_\_ May I call this number? Y N May I leave a message? Y N

E-mail: \_\_\_\_\_

Person responsible for bill: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

### EMPLOYER INFORMATION

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_ May I call this number? Y N May I leave a message? Y N

### INSURANCE INFORMATION

#### Primary Coverage:

Name of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

#### Secondary Coverage:

Name of Insured: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

**MEDICAL & REFERRAL INFORMATION**

Physician/Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Medications (Name & Dosage): \_\_\_\_\_

Therapist/Counselor: \_\_\_\_\_ Phone: \_\_\_\_\_

**HOUSEHOLD INFORMATION**

Spouse/Partner Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Others in home (name):	Gender:	Age:	Relationship:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**EMERGENCY CONTACT INFORMATION**

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Legal Next of Kin: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

	Living?	Age?	Illness/Cause of Death
Father:	Y N	_____	_____
Mother:	Y N	_____	_____
Brother / Sister	Y N	_____	_____
Brother / Sister	Y N	_____	_____
Son / Daughter	Y N	_____	_____
Son / Daughter	Y N	_____	_____



Have you ever been sexually assaulted as an adult? Y N  
Have you ever been physically assaulted as an adult? Y N  
Have you ever been emotionally abused as an adult? Y N  
Are you currently being abused (physically/emotionally)? Y N  
Do you feel safe? Y N Not Sure  
Do you have a safety plan? Y N

I HAVE READ, UNDERSTAND, AND ACCEPT THE OFFICE POLICY:

\_\_\_\_\_  
Signature Date

W. Michael Rogers, Psy.D., P.L.L.C.  
7406 27<sup>th</sup> St. W., Ste 31  
University Place, WA 98466  
Phone: (253) 212-0570  
Fax: (253) 212-0590