DANIEL S. MARR, PSY.D., P.A.

PATIENT REGISTRATION FORM

(Please Print)
Patient's Name:_____ Today's Date: _____

Address: _____

City:_____ State:_____ Zip:_____

Date of Birth: _____ SS#: ___ ___ ___-___ ___-___ ___ ___ ___

Home Phone#: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ Cell# (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Marital Status:_____ Spouse/Significant Other Name :_____

Employer:_____ Work Phone:# (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Can a message be left? **Home** yes no **Cell** yes no **Work** yes no

IN CASE OF EMERGENCY CONTACT:

1. Name: _____ Relationship: _____ Phone#: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

2. Name: _____ Relationship: _____ Phone#: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Who may we thank for referring you?: _____

RESPONSIBLE PARTY/ INSURANCE INFORMATION

Primary Carrier Name (if no insurance mark N/A):_____

Responsible Party/ Policyholder Name: _____ Date of Birth:_____

Relationship to Patient: _____

Employer/Group Name:_____ ID#/ SSN: _____

Primary Care Physician: _____ Phone# _____

I _____ authorize Daniel S. Marr, Psy.D., P.A. to release information to my Primary care Physician for the purpose of coordination of care.
Signature of Patient/Guardian:_____

I authorize and instruct my insurance carrier to make direct payment to Daniel S. Marr, Psy.D., P.A. for the benefits allowable and otherwise payable to me under my current insurance and I authorize Dr. Marr to release any personal information that is required by the insurance company for such payment.
Signature of Patient, Parent, or Guardian:_____ Date: ____/____/_____

Relationship_____

5300 W. Atlantic Ave, Ste 408 · Delray Beach, FL · 33484
Tel: (561) 637-2224 · Fax: (561) 637-4446 · www.drdanielmarr.com

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Patient History

Patient Name:_____ SS#: _ _ _-_ _-_ _ _ _

1. Please briefly state the reason for your visit today: _____

_____

_____

_____

2. Please state who referred you to our office: _____

3. Number of children: _____ Married:_____ Single:_____ Widowed:_____ Other: _____

4. Please specify any physicians you are currently seeing: _____

_____

5. If you have seen a Psychiatrist, Psychologist, or any other Mental Health Professional, please complete the following:

Name of Dr./Professional Date: Month/Year Reason for Visit_____

_____

_____

_____

_____

6. Please list any Medications you are currently taking:

Medication/Dosage Date Started: Doctor: Illness:_____

_____

_____

_____

_____

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7. Please list any previous Psychiatric Medications taken:

Medication/Dosage: _____ Start/End Date: _____ Doctor: _____ Illness _____

_____

_____

_____

_____

Please list any allergies or adverse reactions to any Medications taken: _____

_____

9. Please list any Medical Conditions: _____

_____

10. Please list any past or present use of:

Cigarettes: Yes ____ No ____ Occasionally:____ How much?: _____

Alcohol: Yes ____ No ____ Occasionally: ____ How much?: _____

Over-the-counter drugs: Specify: _____ Yes: ____ No:____ Occasionally: ____

Illegal Drugs: Specify: _____ Yes: ____ No: ____ Occasionally: ____

Other:_____

11. Please include any history of Anxiety or Depression: _____

_____

_____

12. Please state any history of physical handicaps and/or physical or sexual trauma: _____

_____

_____

_____

Signature: _____ Date: _____/_____/_____

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