Date: _____

REGISTRATION FORM

Section I: Patient Information

Name: _____ Prefer to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work: _____ Cell: _____

Date of birth: _____ SSN: _____

Check appropriate box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

If student, name of school: _____ City: _____ ☐ FT ☐ PT

Patient's employer: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Section II Responsible Party

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (____)_____

Employer: _____ Work Phone: (____)_____ SSN: _____

Section III Insurance Information

Name of insured: _____ DOB: _____ Relationship to patient: _____

SSN: _____ Name of employer: _____ Work Phone: (____)_____

Address of employer: _____

Insurance company: _____

Insurance phone: _____ Grp #_____ ID#_____

Insurance address: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ *Yes* ☐ *No IF YES, COMPLETE THE FOLLOWING.*

Name of insured: _____ DOB: _____ Relationship to patient: _____

SSN: _____ Name of employer: _____ Work Phone: (____)_____

Address of employer: _____

Insurance company: _____

Insurance phone: _____ Grp #_____ ID#_____

Insurance address: _____

Welcome to the practice. Thank you for taking the time to complete this form.

DONOVAN WONG, MD
www.donovanwongmd.com
Phone (424) 248-8338 • Fax (888) 612-2969

Date: _____

PAYMENT INFORMATION

I keep your credit card information secure in a clinical file.

YOUR CARD WILL ONLY BE CHARGED WITH YOUR APPROVAL *UNLESS* ONE OF THE FOLLOWING CONDITIONS APPLY:

- **You did not attend a scheduled appointment and no notice was given.**
- **You cancelled an appointment less than 24 business hours in advance.**
- **You attended an appointment but did not pay at time of service.**

.....

I, the undersigned, authorize Donovan Wong, MD to charge my credit card in the event that I (or the party for whom I am financially responsible) fail to attend a scheduled appointment, or if I do not notify Donovan Wong, MD of my inability to attend a scheduled appointment at least 24 business hours in advance (as agreed in the Consent to Treatment Form). Furthermore for outstanding payments of services rendered, I authorize Donovan Wong, MD to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I failed to cancel at least 24 business hours in advance. I authorize Donovan Wong, MD to disclose information about my appointment attendance and/or cancellation history to my credit card company should there be a charge dispute.

Card type (MC, Visa, AmEx or Discover): _____

Card number: _____

Expiration date: _____

CVV code (3 digits, on signature line): _____

Billing address: _____

SIGNATURE: _____ Date: _____

Would you also like to use the above card to pay for your **regularly scheduled sessions**? ☐ Yes ☐ No

If yes, please sign and date below.

SIGNATURE: _____ Date: _____

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www.donovanwongmd.com
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Date: _____

MEDICAL HISTORY

We will discuss your medical history in detail when we meet face-to-face. Below are some brief questions I use to get the conversation started. Please feel free to use the back of this page if there is not enough room for your answers below.

Do you currently take any medications? ☐ Yes ☐ No If yes, please list names and dosages below.

MEDICATION	DOSING INSTRUCTIONS

Do you have any medication allergies? ☐ Yes ☐ No If yes, please list below.

What psychiatric medications have you tried in the past?

Do you currently see a therapist for psychotherapy (talk therapy)? ☐ Yes ☐ No If yes, please provide that person's name and contact information below.

Please list any other physicians you currently see, including primary care physician, neurologist, or any other specialists. Please provide phone numbers if you would like me to be in contact with these practitioners.

Any family history of sudden cardiac death? ☐ Yes ☐ No If yes, please describe circumstances.

Do you have any current or prior medical conditions (including cancer, thyroid problems, high cholesterol, high blood pressure, diabetes, pain issues, headaches, etc.)? Please list below.

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