Saul and Saul, LLC

CONSULTING PSYCHOLOGIST: SUZANNE C. SAUL, PhD

REGISTRATION FORM (PLEASE PRINT)

Name:____

Name I'd Like to Be Called:____

Age:_________Date of Birth:__________________________SSN:___________________________

Street Address:____

City:____Zip:____________________________

Home Phone:__________________________Office Phone:________________________________

Cell Phone:____

E-Mail Address:____

Referred by:____

Occupation:____

Employer:____

Highest Level of Education:____

Marital Status:____

Spouse/Significant Other's Name:_______________________________________

Age:_________Date of Birth:____

Address (If Different from Above):_____________________________________

City:____Zip:____________________________

Occupation:____

Children (Names and Ages):____

____

(Continued on the next page)

Personal Physician:________________________________Phone:________________________

Previous Psychologist(s) and/or Mental Health Provider(s) (Names & Dates Seen):____________

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____

Any Current Medications:____

____

In Case of an Emergency, Name of Contact Person:_____________________________________

Phone:____

Please explain your current concerns which you would like to address:____________________

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I REQUEST CONSULTATION AND TREATMENT BY SUZANNE SAUL, PhD. I HAVE REVIEWED AND UNDERSTAND THE STATEMENT OF OFFICE POLICIES FOR THESE SERVICES. I HAVE BEEN NOTIFIED ABOUT THE LIMITS OF CONFIDENTIALITY.

Print Name:______________________________________**Today's Date:**__________________

Signature:____