



REGISTRATION FOR COUPLES PSYCHOLOGICAL SERVICES

Today's Date: _____

Preferred Pronoun (Couple 1): _____

Full Name (Couple 1): _____

Preferred Pronoun (Couple 2): _____

Full Name (Couple 2): _____

Mailing Address: _____

Couple 1:

Date of Birth: _____

Home Phone: _____

Age: _____

Work Phone: _____

Occupation: _____

Cell Phone: _____

Employer: _____

Email: _____

Please * preferred phone number.

Couple 2:

Date of Birth: _____

Home Phone: _____

Age: _____

Work Phone: _____

Occupation: _____

Cell Phone: _____

Employer: _____

Email: _____

Please * preferred phone number.

Children (Names & Ages): _____

Physician Name (s): _____

Address: _____

Phone Number: _____

Prior Psychological or Psychiatric Services (Clinicians Names & Dates):

Present Psychological Services will be paid for by (please check one):

_____ Ourselves

_____ Other (please specify): _____

Coverage Specifics: Limit Amount \$_____ Percent Covered _____ Renewal Date _____

Direct Billable or Reimbursed? _____ Dr. Note Required? _____

Referral Source (please check all that apply):

_____ Self

_____ Internet Search (google, yahoo, etc.)

_____ Family/Friend/Acquaintance

_____ Association of Psychologists of NS (APNS Website)

_____ Family Physician

_____ My Psychology Website

_____ Internet Advertisement

_____ Other (please specify): _____