NEW PATIENT REGISTRATION FORM (under 18 years old)

PLEASE PRINT CLEARLY

Patient's Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Patient's Phone _____ Patient's Email Address _____

Please indicate if Esther Samadi, M.D., may leave voice messages on the patient's phone. By checking the "yes" box below, you are agreeing to allow Dr. Samadi to leave voice messages, relating to the patient's mental health care, at that phone number.

□ Yes □ No

Birthdate _____ Gender □ Male □ Female

School _____ School's Phone _____

Current Providers:

Psychiatry: □ No □ Yes: Name _____Phone _____

Therapy: □ No □ Yes: Name _____Phone _____

Primary Care: □ No □ Yes: Name _____Phone _____

Medical History:

Medication Allergies: □ No □ Yes: _____

Please list your child's active and/or chronic medical conditions/diagnoses: _____

Please list all current medications, including vitamins and supplements, your child is taking:

Medication Name	Dose (e.g. 2 mg)	Frequency (e.g. twice a day)
1.		

2.		
3.		
4.		
5.		
6.		
7.		
8.		

Parent/Guardian's Contact Information (PARENT/GUARDIAN #1):

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell Phone _____

Business Phone _____ Email Address _____

Please indicate where Dr. Samadi may leave you voice messages. You may check more than one. By checking a box below, you are agreeing to allow Dr. Samadi to leave voice messages, relating to your child's mental health care, at that phone number.

□ Home □ Cell □ Business

Birthdate _____ Gender □ Male □ Female

Employer _____ Occupation _____

Parent/Guardian's Contact Information (PARENT/GUARDIAN #2):
Please feel free to write "Same as above" for any appropriate items

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell Phone _____

Business Phone _____ Email Address _____

Please indicate where Dr. Samadi may leave you voice messages. You may check more than one. By checking a box below, you are agreeing to allow Dr. Samadi to leave voice messages, relating to your child's mental health care, at that phone number.

□ Home □ Cell □ Business

Birthdate _____ Gender □ Male □ Female

Employer _____ Occupation _____

Signature _____ Date _____
(Parent/Guardian #1)

Signature _____ Date _____
(Parent/Guardian #2)