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(813) 732-6717

NEW PATIENT INFORMATION

Name: _____
(first) (middle) (last)

Home address: _____
_____

Mailing address (if different from above):_____
_____

Home phone: (_____)_____

Work phone: (_____)_____

Cell phone: (_____)_____

Email: _____

Birthdate: _____ Birthplace:_____

Marital status: S___ M___ D___ W___

Referred by: Name: _____
(Please check one)
Psychology Today: _____
Therapy Tribe: _____
Theravive: _____
Other: _____

May I thank the person who referred you? Yes___ No___

Reason for seeking treatment: _____
_____
_____
_____

Previous psychotherapy or psychiatric treatment (dates, location, reason for treatment):
_____
_____

I understand that I am responsible for the full amount of my bill for services provided. There is a cancellation policy which requires that you **cancel your appointment 24 hours in advance in order to avoid being charged for that session.**

_____ _____
Patient signature Date