ClearPath Psychiatry & Counseling

Patient Registration

Full Name: _____ Date of Birth: _____
Age: ____

Gender Identity: _____ Pronouns: _____ SSN (last 4): _____

Street Address:
_____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ OK to leave voicemail? ☐ Yes ☐ No

Email Address:
_____

Marital Status: _____ Employment Status: _____

Employer / School:
_____