Marks
Psychiatry

Tracey I. Marks, MD

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Last name	First	Middle Initial

Birth date:	Age:	Sex: ☐ M ☐ F	Home phone no:	Okay to leave message? ☐ Yes ☐ No

Street Address:	City:	State:	ZIP Code:

Cell phone no:	Okay to leave message? ☐ Yes ☐ No	Preferred phone for message? ☐ Home ☐ Cell

REFERRAL INFORMATION

How did you find me? (check all that apply): Dr. Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Internet search

What words did you search for:

REASON FOR VISIT

I am primarily interested in (choose one or more):

☐ finding a new psychiatrist ☐ second opinion diagnosis ☐ changing my medications

☐ therapy to help with relationships ☐ talk therapy by I'm not sure what the problem is ☐ professional support during a difficult time

☐ seeing if I need medication for _____

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient	Contact phone

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