**Pamela A. Pappas MD, MD(H)**
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# REGISTRATION FORM

Today's date:

## PATIENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Patient's last name: First: Middle: | | | ❑ Mr. ❑ Mrs. | ❑ Miss ❑ Ms. | ❑ Dr. |
| Marital Status: | Birth date: / / | Age: | Sex: ❑ M ❑ F | Occupation | |
| Street address: | | | Home phone: ( ) | | |
| City: | State: | ZIP Code: | Email address: | | |
| Cell phone: ( ) | Work phone: ( ) | | Preferred number for messages ❑ Home ❑ Cell ❑ Work | | |

## REFERRAL INFORMATION

| | | | | |
|---|---|---|---|---|
| How did you find me? Please check all that apply: | | | ❑ Dr. | |
| ❑ Family | ❑ Friend | ❑ Close to home/work | ❑ Yellow Pages | ❑ American Institute of Homeopathy ❑ National Center for Homeopathy |
| ❑ Internet search | | ❑ American Holistic Medical Association | | ❑ AZ Center for Integrative Medicine (Dr. Weil) |

## REASON FOR VISIT

I am primarily interested in [please choose one or more]:

| | | | |
|---|---|---|---|
| ❑ finding an Integrative Psychiatrist | ❑ Classical Homeopathy | ❑ talk therapy | ❑ collaborative care with another doctor, therapist, or practitioner |
| ❑ professional support during a difficult time | ❑ Mentoring ❑ Coaching | | ❑ Second opinion for psychiatric treatment |
| ❑ Other | | | |

## IN CASE OF EMERGENCY

| | | | |
|---|---|---|---|
| Name of local friend or relative | Relationship to patient: | Home phone: ( ) | Work phone: ( ) |

The above information is true to the best of my knowledge. I understand that I am directly responsible for all fees. Dr. Pappas will provide documentation for me to submit for out of network insurance coverage for my visits, but reimbursement depends on my insurance policy.

**Patient Signature** **Date**