Advanced Therapy Center

PATIENT INFORMATION

Patient Last Name:	Patient First Name:		Patient DOB:
Street Address:		Patient Home Phone:	
City:	State:	Zip:	Patient Cell Phone:
Patient Email Address:			
Patient Emergency Contact (Name/Phone Number)			
How did you learn about Advanced Therapy Center?			
Primary Care Provider Name:			
Primary Care Provider Address:			Phone Number:
List all Medications:			
Reason for today's visit:			
Any recent or current health concerns?			
Is there anything else you want to be sure I know?			
I have read and agree to the procedure and policies outlined in the **Outpatient Services Contract**. Patient Signature (or parent, if minor): Date:			

Candia Smith, DMH
Psychology License PSY 12502

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