

Patrick Fitzsimmons, M.D.  
Board certified in psychiatry and geriatric psychiatry

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**Registration Form**  
(Hand deliver at our first meeting.)

Date \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_

Date of birth \_\_\_\_\_

Gender      Male              Female              Other \_\_\_\_\_

Referred by whom \_\_\_\_\_

Primary care doctor, with phone number \_\_\_\_\_

**Mailing address**

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

**Telephone numbers** (List only those numbers that are okay for me to call if I need to reach you. Indicate whether it is okay for me to leave a message with confidential information.)

Message with confidential information OK?

Home (\_\_\_\_\_) \_\_\_\_\_              Yes              No

Cell (\_\_\_\_\_) \_\_\_\_\_              Yes              No

Work (\_\_\_\_\_) \_\_\_\_\_              Yes              No

**Emergency contacts**

Individual #1's name \_\_\_\_\_              Relationship to you \_\_\_\_\_

Telephone number(s) \_\_\_\_\_              \_\_\_\_\_

Individual #2's name \_\_\_\_\_              Relationship to you \_\_\_\_\_

Telephone number(s) \_\_\_\_\_              \_\_\_\_\_