Dr. Mark Rothman, Psy.D.
Registered Psychologist
Toronto, Ontario
T: 416 562-7815, Email: Drrman@Rogers.com

Name of Client: **Date:** / /

Date of Birth: / / **Age** **Sex: M F**

Address: **Postal:** -
Home Phone: **Fax:** **Other Phone/Pager**

School: **Grade:**

Additional Education(if applicable):

Mother's Name ________________________ **Mother's DOB:** _________ **Age** _____

Occupation ___________________ Employer ____________ Work phone

Father's name _______________________ **Father's DOB:**________ **Age**_______

Occupation _________ __Employer _________________ Work phone

Parent's marital status __________ # of years ________
Step parent's name (If any) ___________________

If divorced, who has custody?

Special billing arrangements
Contact person

Special telephone procedures: (Leave message etc.)

Brothers/Sisters Birth Town School Grade

____

____

____

____

____

____

Pediatrician/GP Name Address Phone

______________ ____________________ ____________

Reason for referral:

Current health problems:

Current medications:

Current Allergies:

Who referred you here?

Emergency contact person Relationship Phone

*ANY INFORMATION PROVIDED BY YOU IS CONFIDENTIAL AND **WILL** NOT BE **DISCLOSED** TO ANY PERSON WITHOUT YOUR EXPRESSED CONSENT*

I am personally responsible for payment of this account which Includes appointments cancelled within 24 hours of appointment time and for subsequent collection costs if necessary. I understand that the current fee for service is $225.00 per clinical hour.

Signed:____ Date:

If it is necessary to send a bill, a $5.00 charge will be added to your account