**MICHAEL SCHOTTENSTEIN MD**
**Child, Adolescent, Adult Psychiatry**
**2700 East Main Street, #206 * Columbus, Ohio 43209**
**(614) 470-5582**

# Registration Form

## Patient Information:

Full Legal Name: (Last)_____First_____MI____
Address:_____
City:_____State_____Zip_____
County_____Home Phone#_(___)_____
Work Phone# (_____)_____Cell# (_____)_____
Employer (or school) _____
Date of Birth:_____Age_____Sex_____
Social Security #_____Marital Status:_____

## Responsible Party Information (Parent)

Name: (Last)_____First_____MI_____
Address_____
City:_____State_____Zip_____
Home Phone#: (___)_____ Work Phone#_(___)_____
Cell # (_____)_____
Patient's Relationship to responsible party:_____

## Referral Information

Name: Last_____First_____MI_____
Business Name_____Phone# _(___)_____
Cell#_____
Address:_____City_____State_____Zip_____

## Primary Care Physician

Name: Last_____First_____
Business Name_____Phone#_(___)_____
Address_____City_____State_____Zip_____