Sunshine Collins, PsyD
Licensed Psychologist
Clinical, Forensic, & Family Psychology

Personal Information

Patient Name			
New Patient?	How did you hear about us?		
Sex	DOB	Age	Marital Status
Phone	Okay to leave voicemail?	Email	Okay to send email?
Address			Apt/Space/Unit
City	State		Zip
Emergency Contact Name		Phone	Relationship

If applicable:

Parent/Guardian Name	Phone	Relationship
Parent/Guardian Name	Phone	Relationship

I attest that the above information is complete and correct. I understand that professional services rendered are charged to the patient. **The patient is responsible for all fees.** In the event of collection proceeding due to the lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due to the doctor. A copy of this document is valid as the original.

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Patient / Guardian Signature Date