# CRAIG W. BEAVER, PH.D.

## PATIENT REGISTRATION

**Name_____ Date of Birth_____**

**Address_____**

**City_____State_____Zip_____**

**Telephone Number:_____**

**Alternate Contact Person:_____**

**Telephone Number_____ Relationship_____**

**Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed**

**I hereby authorize Craig W. Beaver, Ph.D. to bill for provided services which I have received by him and/or his staff and assign payment for those services to Craig W. Beaver, Ph.D.**

**Date_____ Signature_____**