

# Compass Research, LLC

100 West Gore Street, Suite 202

## Registration Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_  
Date \_\_\_/\_\_\_/\_\_\_

Referred by (Please Be Specific) \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Cell Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_ Work Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Sex  Male  Female Marital Status  Single  Divorced  Married  Widowed  
Race (Optional) \_\_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_

Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's Work Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_  
May we contact your spouse?  Yes  No

Parent or Guardian's Name \_\_\_\_\_ Occupation \_\_\_\_\_  
Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Contact Person(s) in Case of Emergency \_\_\_\_\_ Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_  
\_\_\_\_\_ Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (\_\_\_\_)-\_\_\_\_-\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Do you have internet access?  Yes  No E-Mail \_\_\_\_\_

May we contact you?

|          |                              |                             |
|----------|------------------------------|-----------------------------|
| Home     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Cell     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Work     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Internet | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

*I agree, as a guest of Compass, to honor the rights of privacy of any person(s) at Compass. I further agree not to divulge any information regarding any patient or client, which I may observe while visiting Compass.*

Signature \_\_\_\_\_