PATIENT INFORMATION FORM

NAME:_____
LAST FIRST MI

ADDRESS: _____
STREET

_____
CITY STATE ZIP

HM PH: _____ **WK PH:** _____ **EXT:** _____

CELL: _____ **Ok to call you at work?**_____

SOCIAL SECURITY #: _____

D.O.B.: _____ **SEX:** _____ **MARITAL STATUS:**_____

OCCUPATION: _____

EMPLOYER: _____

INSURANCE COMPANY: _____

MEMBER ID #: _____

REFERRED BY: _____

SPOUSE:_____ **SPOUSE'S MAIN PHONE #:** _____

ARE YOU CURRENTLY SEEING ANOTHER PSYCHIATRIST? _____
If yes, what is the reason for today's visit? (Please check one)
- ☐ **I want to change doctors;**
- ☐ **I would like a 2nd opinion;**

Other _____

This office does not file for insurance. For private insurance we will provide you with a receipt to allow you to file your claim.

This provider is not a participant of the Medicare/Medicaid insurance programs.

MEDICATIONS PATIENT MAY BE ALLERGIC TO:

_____

IN CASE OF EMERGENCY_____
NAME RELATIONSHIP

_____
HOME PHONE WORK PHONE

SIGNED: _____ **DATE:** _____ Print Form

(THIS FORM MUST BE SIGNED AND DATED PLEASE)