

PATIENT INFORMATION
CONFIDENTIAL-FOR BILLING & PROFESSIONAL USE ONLY

Today's Date _____

Patient Name _____ Date of Birth _____

Address _____ City/State/Zip _____

Home Phone _____ Work Phone _____ Cell _____

Social Security # _____ Employer _____

Drivers License Number _____

Marital Status _____ Spouse's Name _____

Emergency Contact

Name _____ Relationship _____

Phone _____ Work _____ Cell _____

If you are not responsible for payment, give name & address of responsible party:

Brief description of reason for this visit: _____

Primary Care Physician _____ Phone _____

Would you like us to share information with your primary care physician? YES _____ NO _____

When was your last physical exam? _____

Please list any known medical problems:

Please list any medications or over-the-counter treatments you are currently taking:

Name	Dose / Schedule	Name	Dose / Schedule
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you currently working with a psychiatrist? YES _____ NO _____ Name _____