New Patient Forms

Patient Information

Full Name

First_____ Middle_____ Last_____

Sex: Circle one- Male Female Other **Date of Birth _____/_____/_____**

Primary Phone _____

Email _____ Social Security Number _____

Address _____

City _____State _____ Zip _____

Marital Status _____ Maiden Last _____

Driver's License State _____Driver's License # _____

Demographics

Sexual Orientation _____Gender Identity_____

Hispanic or Latino? _____ Ethnicity _____

Race _____Language _____

Emergency Contact

Relationship to Contact _____

Full Name

First_____ Middle_____ Last_____

Phone Number _____Email_____

Address_____

City_____State_____Zip_____

Financial Information

****PAYMENT INFORMATION WILL BE COLLECTED PRIOR TO YOUR FIRST APPOINTMENT****

Responsible Party
Who will be financially responsible for you? Circle one- Myself or Someone Else
If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

First_____ Middle_____ Last_____

Phone Number _____Email_____

Care Team Information

Primary Care Provider

Name _____

Office Number _____

Previous Psychiatric Provider

Name_____

Office Number_____

Current Counselor/Therapist

Name_____

Office Number_____

Medications

Please list all current medications

_____

_____

Additional Information

Please list your preferred pharmacy

Pharmacy Name_____

Phone Number _____

Whom can we thank for telling you about us?_____