Patient Information Sheet

Patient Information:

First Name: (as it appears on insurance card): Middle Initial: Last Name:

Address: Apt: State: Zipcode:

Mailing Address: (if different than above) Apt: State: Zipcode:

Home Phone: Cell Phone: Email:

Social Security # : Employment Status: Date of Birth: ______/_______/________

We require the following information for the purposes of helping our staff use the most respectful language when addressing you or your family member and understanding our population better. Please help us by selecting the best answers to the questions below. Thank You.

Gender Identity: Pronoun Preference: Marital Status: How did you hear about the center:

Parent/Guardian Information (if applicable):

Name: Phone No: Email:

Name: Phone No: Email:

Insurance Information:

Insurance Carrier: Insurance ID: Group No:

Insurance Address: City: State: Zipcode:

Insurance Holder Name: DOB: ______/_______/______ SS#:

Insurance Holder Phone#: Gender: Relationship to Pt:

Insurance Holder Address (if different than above):

Additional Information:

Emergency Contact Name: Phone No: Relationship to Pt:

School Name (if applicable): Grade: Phone#:

School Counselor (if applicable): Phone #:

Primary Care Physician: Phone#: Fax #:

Psychiatrist/Prescriber: Phone#: Fax#:

Referred By: Phone#:

The Center will not contact outside professionals without the informed consent of patients, parents, or guardians.

Current Medications:

Name	Dosage	Frequency	Reason

By signing below the Patient, or authorized person, authorizes provider to release information to insurance carriers listed on this form, and to subsequently billable insurance carriers, and authorizes provider to be paid directly by insurance carriers for services billed to carrier on behalf of the patient. If filled out online a typed name will be considered to be a signature.

Patient Name: Patient Signature: Date: ______/______/______

Authorized Signer Name: Signature: Date: ______/______/______

For Office Use Only (Clinician please fill out below):

Consent for Referral Source:	Yes	No	NA
Contact with Referral Source:	Yes	No	NA
Consent for PCP:	Yes	No	NA
Contact with PCP:	Yes	No	NA
Consent for Prescriber:	Yes	No	NA
Contact with Prescriber:	Yes	No	NA

If there was no contact with PCP or prescriber please explain why: ____

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