New Patient Information Form

Patient Name:		
Home Address:		
Telephone	Home: Cell:	Work:
E-Mail :		
SSN:		DOB:
Relationship Status: ☐Single ☐Married ☐Partnered ☐Separated ☐Divorced ☐Widowed		
Employer Name:		

Medical Information and History

Primary Care Physician:
Phone:
Medical History (Major Illnesses, Hospitalizations, Current Conditions):
Current Medications you are taking (Name, dosage, frequency):
Previous therapy:
Have you ever been on psychotropic medication? If so, what type and when?

Emergency Contact Information

Emergency Contact Name:	
Phone Numbers: Home	Work

Insurance Information

Please read the section on Using Insurance in the Outpatient Services Contract. If you want to use insurance, please bring your card **and** a copy of your card to the first meeting. Also make sure you double-check benefits, applicable co-pays, deductible, and the address for billing.

Insurance Co:
Card Holder's Name
Member ID#
Group #

What are you wanting help with at this time?

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