ASSOCIATES FOR PSYCHIATRIC SERVICES, P.C.

PATIENT DEMOGRAPHICAL INFORMATION

Date_____ Patient's Name_____ Birth Date____/____/____

Address_____ City_____ State_____ Zip Code_____

Home Phone No._____ Can we leave a message on this number? ☐ Y ☐ N

Cell Phone No._____ Can we text you on this number? ☐ Y ☐ N

Work Phone No._____ Email _____

Social Security No._____ Marital Status: ☐ M ☐ S ☐ W ☐ D Sex: ☐ M ☐ F

Employer_____ Employer's Address_____

Occupation_____ Retired: ☐ Y ☐ N Student: ☐ Y ☐ N

Race _____ Ethnicity _____ Language _____

Spouse's Name (if applicable)_____ Birth Date____/____/____

Address_____ City_____ State_____ Zip Code_____

Social Security No._____ Marital Status: ☐ M ☐ S ☐ W ☐ D Sex: ☐ M ☐ F

Employer_____ Employer's Address_____

Occupation_____ Retired: ☐ Y ☐ N Student: ☐ Y ☐ N

Mother's Name (if applicable)_____

Address_____

City_____ Zip Code_____

Birth Date____/____/____

Home Phone No._____

Cell Phone No._____

Work Phone No._____

Employer_____

Employer's Address_____

Occupation_____

Social Security No._____

Father's Name (if applicable)_____

Address_____

City_____ Zip Code_____

Birth Date____/____/____

Home Phone No._____

Cell Phone No._____

Work Phone No._____

Employer_____

Employer's Address_____

Occupation_____

Social Security No._____

For billing purposes, please place an "X" by the responsible party: Patient_☐_ Mother_☐_ Father_☐_

Are you involved with community support services? ☐ Y ☐ N If yes, with whom: _____

Name and Address of Referral Source_____ May we contact: ☐ Y ☐ N

Name and Address of Family Physician_____ May we contact: ☐ Y ☐ N

In case of emergency, contact: Name_____ Phone Number _____

INSURANCE INFORMATION

Please present insurance card(s) so a copy may be kept on file.

Primary Insurance_____

Secondary Insurance_____

Is this through an Employee Assistance Program? ☐ Yes ☐ No