



PERSONAL INFORMATION

Name _____ Age _____ Date of Birth _____
 Address _____ City _____ State _____ Zip _____
 SSN _____ Home Phone _____ Other Phone _____
 Emergency Contact _____ Phone _____
 Married (Yes/No)____ Number of times married ____; Number of times divorced ____ Widowed ____
 Number and ages of children _____
 With whom do you live (relationship of any) _____
 Name/relationship of person filling out form, if not patient _____

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Depression						
Anxiety						
Panic Disorder						
Manic Depression						
Schizophrenia						
Alcohol Abuse						
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Diabetes						
Epilepsy						
Thyroid Disorder						
Parkinson's Disorder						
Alzheimer's Disease						
Occupation						
Age at Death						
Cause of Death						

We request a 24 hour advance cancellation notice to avoid a missed appointment charge. Our phone is answered 24 hours a day, seven days a week to take urgent calls and cancellations. **Calls for medication refills will be answered the next business day, when your chart is available for review.** Please check your medications regularly and make appointments before the supply is exhausted to discuss any changes and obtain the necessary new prescription. We will file your insurance as a **courtesy** to you. **However,** payment is ultimately the responsibility of the patient or the responsible party named below.

I authorize the release of any medical information necessary to process this claim. Additionally, I request payment of medical benefits to the physician or supplier for services rendered to the above named patient.

By _____ Date _____
Signature

Name _____
Patient Name or Guarantor of Patient