

Psychiatric & Psychological Associates of Durham, PLLC

PATIENT INFORMATION

Patient's Name: Last First Middle Date of Birth:

Home Address: Street City State Zip Home Phone # Work Phone # Cell Phone # Social Security #:

Male [ ] Female [ ] Marital Status Referred By:

Employed By Occupation Work Address / Street City State Zip

Spouse or Legally Responsible Adult Home Phone # Work Phone # & Address City State Zip

ADULT (Other than self, parent/guardian) TO CONTACT IN THE EVENT OF AN EMERGENCY:- Name:

Relationship Home Phone # Work Phone # Address: Street City State Zip

Name of Primary Care Physician: Phone #: FAX #:

XX

INSURANCE AUTHORIZATION

Name of Managed Care Organization: Authorization #:

Who did you speak to? Date Obtained:

XX

IF PATIENT IS A CHILD OR ADOLESCENT - Please fill out the following family information:

FATHER'S Name: Date of Birth: Social Security #

Home Address: Street: Home Phone #: Work Phone #:

City/State/Zip: Cell Phone #:

Employed By Occupation Work Address / Street City State Zip

MOTHER'S Name: Date of Birth: Social Security #

Home Address: Street: Home Phone #: Work Phone #:

City/State/Zip: CellPhone #: Work Phone #:

Employed By Occupation Work Address / Street City State Zip

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PPAD Clinician: Date of Initial Visit: