Patient Intake form

My Psychiatrist, PLC

(To be completed on first visit)

Patient Information				
First Name	Middle Name		Last name	Sex
Address Street		Apt/Suite	SSN:	
City	State	Zip	Age	Date of Birth
Phone (Home)	Phone (Cell)	Phone (work)	Email address:	

Billing Information			
Responsible (skip if this info is same as above)			
Address Street		Apt/Suite	
City	State	Zip	Phone Number

Primary Insurance			
Insurance Company Name		Effective Date	Exp Date
Policy Holder Name	Relationship	Policy Holder Date of Birth	Policy Holder SS #
Identification/Policy Number	Group Number	Policy Employer's Employer Name	Phone Number

Secondary Insurance (Medicare Supplement or Secondary Insurance)			
Insurance Company Name	Effective Date	Exp Date	
Policy Holder Name	Relationship	Policy Holder Date of Birth	Policy Holder SS Number
Policy Number	Group Number	Policy Employer's Employer Name	Phone Number

Parents/Legal Guardian Information (for Children only)			
Full Name		Relationship	DOB
Street Address (if different than Patient)		State City	Zip
Home Phone	Cell Phone	Work Phone	

Emergency Contact			
Full Name	Relationship	Phone #	Cell phone #

How did you Know about us?	☐ Internet	☐ Relatives Friends	☐ Insurance Co.	☐ Therapist	☐ Our clients
☐ Physician ☐ Others	Name of the Referring Physician/Therapist			Phone Number	

Office Use Only	Patient ID #	Date: