INTEGRATIVE PSYCHIATRY AND PSYCHOTHERAPY PLLC
NEW PATIENT INFORMATION SHEET

Name:_____Age:_____DOB:_____

Address:_____

Telephone:_____Cell:_____Work:_____

Email address:_____

May we contact you at home? Yes___ No___ At work? Yes___ No___

Parent/Guardian if under 18 (circle one)_____

Do you have primary custody? Yes___ No___

Referred by_____

Primary MD_____

EMERGENCY CONTACT (parent-guardian if minor)

Name: _____ Telephone: _____

Relationship to
patient_____

I acknowledge receiving and reading a copy of the Office Policy and Procedures.

Patient(print)_____

Patient(sign)_____ Date:_____

Parent/Guardian(print)_____

Parent/Guardian(sign)_____ Date:_____