mind matters, P.C.
CHILD & FAMILY PSYCHIATRY
Healing Minds, Changing Lives

PATIENT INFORMATION

Legal Name: First Middle Last				Preferred Name:
Date of Birth:	Sex: ☐M ☐F	Gender (*if different*):	Social Security #:	Primary Phone #: ☐cell ☐home
Mailing Address: City State Zip				Secondary Phone #: ☐cell ☐home
Primary Email Address:		Secondary Email Address:		It is ok to leave detailed information at this Phone #: ☐Primary ☐Other: ☐Secondary
Who does the patient live with?			Other family members seen at this office: (*please list first and last names*)	
PRIMARY CARE PHYSICIAN: (Name, Address and Phone #)				
PHARMACY: (Name, Address, and Phone #)				
Parent Name:			Date of Birth:	Primary Phone #: ☐cell ☐home
Home Address: (*if different from patient*)			Social Security #:	Secondary Phone #: ☐cell ☐home
Parent Name:			Date of Birth:	Primary Phone #: ☐cell ☐home
Home address: (*if different from patient*)			Social Security #:	Secondary Phone #: ☐cell ☐home

FINANCIAL GUARANTOR INFORMATION

Legal Name: First Middle Last				Preferred Name:
Guarantor Date of Birth:	Sex: ☐M ☐F	Gender: (*if different*)	Social Security #:	Relationship to Patient:
Mailing Address: (*If different from patient*) City State Zip				Primary Phone #: ☐cell ☐home
Email Address:		Employer:		Business Phone #:

EMERGENCY CONTACT

Full Name: (*Someone not living with you*)	Primary Phone #: ☐cell ☐home	Relationship to Patient:

INSURANCE INFORMATION

(Primary Insurance)			(Secondary Insurance)		
Insurance Company:			Insurance Company		
Subscriber Name:			Subscriber Name:		
Employer:		Insurance Phone #:	Employer:		Insurance Phone #:
ID Number:		Group Number:	ID Number:		Group Number:
Subscriber Date of Birth:	Sex: ☐M ☐F	Gender: (*if different*)	Subscriber Date of Birth:	Sex: ☐M ☐F	Gender: (*if different*)
Subscriber Address: (*if different from above*)			Subscriber Address: (*if different from above*)		