

# Comprehensive Psychiatric Care, P.C.

## Patient Demographics

### PATIENT

Last: First: MI:  
Cell Phone: Home Phone: Work Phone:  
Address: City: State: Zip:  
DOB: SS #: Sex: Marital Status:  
Primary Care Physician:

### RESPONSIBLE PARTY

Last: First: MI:  
Home Phone: Work Phone: Ext:  
Address: City: State: Zip:

### INSURANCE

#### SUBSCRIBER:

Last: First: MI:  
DOB: SEX: SSN: Relationship to Pt:  
Insurance Company: ID #:  
Employer:

### EMERGENCY

Contact: Phone #:

Please be aware that by providing an emergency contact you are authorizing Comprehensive Psychiatric Care to contact this person in situations of crisis or prolonged absence from treatment. \_\_\_\_\_ (please initial to approve)

### REFERRAL SOURCE:

Referred to this office by: