Arkansas Psychiatric Clinic

Name of Doctor or Clinician you will be seeing today:_____ **Date:**_____

Who referred you to our office?_____

PATIENT INFORMATION

Name_____ Date of Birth_____ SS#_____
First Middle Last

Mailing Address_____ City_____ Zip_____

Residence Address_____ City_____ Zip_____

Residence Telephone_____ Work Telephone_____

In case of EMERGENCY contact_____ Telephone_____

Employer's Name_____

Employer's Address_____

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widow/Widower

Are you allergic to any medications? Yes_____ No_____ If Yes, list name of medication_____

If, Patient Is A Student – Please Check One ❑ Full-Time Student ❑ Part-Time Student

NAME OF SCHOOL ATTENDING_____

BILLING INFORMATION

Person responsible for paying bill: ❑ Patient ❑ Parent ❑ Spouse ❑ Other

Name (if Different from above)_____ Date of Birth:_____

Address_____ City_____ Zip_____

Residence Telephone_____ Work Telephone_____

Employer's Name_____

Employer's Address_____