Weiss Therapy Centers

Patient ID #_____

PATIENT INFORMATION

Please fill in as completely as possible. We must have a current address and phone number to contact you.
If patient is under 18, please fill in the "Minor Patients" section also.

Patient Name: _____ ☐ M ☐ F Date of Birth: _____ /_____ /_____
(Last Name) (First Name) (MI)

Age:_____ **SS#** _____ - _____ - _____ ☐ Single ☐ Married ☐ Other Primary Language Spoken:_____

Address: _____

City: _____State: _____Zip Code: _____

Home/Eve Number: (_____) _____ - _____ Work Telephone Number: (_____) _____ - _____

Cell Number: (_____) _____ - _____ E-Mail Address:_____
(If provided, you may receive our e-newsletter, updated info about our office, etc.)

Employed: ☐ Full Time ☐ Part Time ☐ Military ☐ Retired - Month/Year_____ Occupation:_____

Employer:_____ Attend School at:_____

For Minor Patients (Under 18yrs. of age) *All Shared Guardians have a right to treatment information. If you have special circumstances, please bring in the Court Documents to support your case.*

Primary Guardian Contact Name:_____ **(Responsible for appointments, insurance info, etc.)**

SS#_____ - _____ - _____ ☐ Mother ☐ Father ☐ Step Mom ☐ Step Dad ☐ Other Primary Language Spoken:_____

Home/Eve Number: (_____) _____ - _____ Work Telephone Number: (_____) _____ - _____

Cell Number: (_____) _____ - _____ E-Mail Address:_____
(If provided, you may receive our e-newsletter, updated info about our office, etc.)

Other Legal Guardian Name & Relationship to patient: _____ **SS#**_____ - _____ - _____

Home/Eve Number: (_____) _____ - _____ Work Telephone Number: (_____) _____ - _____

Cell Number: (_____) _____ - _____ E-Mail Address:_____
(If provided, you may receive our e-newsletter, updated info about our office, etc.)

By providing all of the information above, I give authorization for Weiss Therapy Centers to contact me at the above address by mail or at the above phone numbers and may leave a message regarding appts. or necessary insurance info, etc. Exceptions are as follows: _____

_____

PATIENT MEDICAL INFORMATION

Are you Allergic to Any Medication: ☐ YES ☐ NO If so, which one (s):_____

Are you currently taking Psychiatric Medications? ☐ YES ☐ NO Name of Psychiatrist or prescribing Physician:_____

Previous Behavioral Health visits in the past 12 months with a Psychiatrist/Therapist?: ☐ YES ☐ NO

Emergency Contact Person: _____ Phone #:_____

Relationship to Patient: _____ ☐ MAY ☐ MAY NOT receive info on my treatment.

How did you hear about us?_____