JOHN R DAY & ASSSOCIATES, LTD
CHRISTIAN PSYCHOLOGICAL ASSOCIATES

NEW PATIENT INFORMATION

First Name: _______________________________ **MI:** _____ **Last Name:** ____

Address: ____

City: __________________________________ **State:** _______ **Zip Code:** ____

Home Phone #: __________________ **Cell Phone #** _________________ **Work Phone #:** __________________________

Email: _________________________________**Social Security #:** ___________________ **Date of Birth:** _______________

Place of Employment: ___________________________________ **Job Title:** ______________________________________

Marital Status (Circle One): **Single** **Married** **Divorced** **Separated** **Widowed**

Parent's Name (if minor): ____

Emergency Contact:

Name: ____ **Relationship to Patient:** _____________________________

Address: ____

City: _____________________________________ **State:** ________ **Zip Code:** ____________________________________

Home Phone #: __________________ **Cell Phone #:** _________________ **Work Phone #:** _________________________

Coordination of Care with Primary Care Physician and/or Psychiatrist

Who is your medical doctor? __________________________________ **Phone #** __________________________________

May we contact your doctor? Yes /No OR I do not have a medical doctor __

*****IMPORTANT: If you answer YES, please complete the Release of Information sheet.*****

Who is your psychiatrist? _____________________________________ **Phone #** _________________________________

May we contact your psychiatrist? Yes/No OR I do not have a psychiatrist ___

***** IMPORTANT: If you answer YES, please complete the Release of Information sheet.*****

Are you allergic to any meds? If YES, please list: ____

____ _______________________________

Patient/Parent/Guardian/ Responsible Party Signature **Date**