Psychological Solutions of Lake Norman, PLLC
ADULT PATIENT INFORMATION FORM

Today's Date: _____

Patient's Name: _____

Person Completing Form: _____ **Relationship:** _____

Patient's Date of Birth: _____ / _____ / _____ Age: _____

Patient: Male ____ Female ____ Other_____

Patient's Social Security Number: _____

Race (optional): _____ Native American Yes__ No__ Hispanic/Latino Yes__ No__

Patient's Address: _____

_____

Cell Phone #:_____ Home#: _____ Preferred: Cell __ Home __

Email #: _____

Patient's Employer: _____ Occupation: _____

Work Phone #: _____ Retired/Past Occupation: _____

In the Event of an Emergency, Who Should We Contact?

Full Name: _____ Relationship to Patient: _____

Emergency Contact Phone: _____

Please list, if any, person(s) with whom we may discuss your medical history, diagnoses, the content of the current evaluation, and/or financial account:

Name:_____ Phone#:_____

Relationship to patient:_____

Name:_____ Phone#:_____

Relationship to patient:_____

Name:_____ Phone#:_____

Relationship to patient:_____

(advise PSOLN if you need to add additional individuals)

I understand that this authorization can be revoked at any time by submitting a written request of revocation to Psychological Solutions of Lake Norman. We will then stop sharing your information. However, if we have already shared some of the information, then this cannot be changed.

Patient Signature: _____

Date: ____ / ____ / _____

Witness: _____