Name:_____

DOB:_____ **ID:**_____

Patient Demographics Form

Name: _____ Today's Date: _____/_____/_____
Last First M.I

Refer to patient as: _____ DOB: _____/_____/_____ Age: _____

Home address: _____ Apt #: _____

City:_____ State:_____ Zip:_____ SSN: _____

Home Phone:_____ Cell Phone:_____ Work Phone: _____

Email: _____ Height: _____Weight: _____

How may we contact you with appointment reminders? ❑ Text ❑Email ❑Phone call

Employment Status: ❑Employed ❑Self-Employed ❑Homemaker ❑Stay-at-home Parent
❑Full-time Student ❑Part-time Student ❑Disabled ❑Unemployed ❑Retired

School or Employer:_____ Grade:_____

Ethnicity:_____ Religion:_____ Preferred Language:_____

Do you have a Medical Power of Attorney? **❑Yes ❑No Representative Name:** _____

Do you have a Mental Health Power of Attorney? **❑Yes ❑No Representative Name:** _____

Do you have a Legal Guardian/ Fiduciary? **❑Yes ❑No Representative Name:** _____

Paperwork of MPOA/ MHPOA/ Guardianship copies provided: **❑Yes ❑No**

Patient's Condition

Date of Current Illness Onset: _____ Date of Similar Illness: _____

Date of Current Hospitalization: From _____ To _____

Dates Unable to Work: From _____ To _____

Condition related to Employment? ❑Yes ❑No

Condition related to Auto Accident? ❑Yes ❑No If yes, State of accident: _____

Condition related to Other Accident? ❑Yes ❑No

Contacts

Emergency Contact Name: _____ Emergency Contact Number: _____

Relationship to Emergency Contact: _____ Contact Notes: _____

Contact	Name	Phone	Fax
Primary Care Physician			
Case Manager			
Pharmacy			

brain solutions

Name:_____

DOB:_____ **ID:**_____

Primary Insurance

Insurance Company Name: _____

Policy #: _____ Group #: _____ Copay/Deductable: _____

Carrier Address: _____

City:_____ State:_____ Zip:_____ Carrier Phone:_____

Patient Relationship to Insured:_____

Insured Name: _____
Last First M.I

Insured Address: _____ Apt #: _____

City:_____ State:_____ Zip:_____ Insured Phone: _____

Insured Date of Birth: _____/_____/_____ Insured Gender: _____

Insured Employer: _____

Secondary Insurance

Insurance Company Name: _____

Policy #: _____ Group #: _____ Copay/Deductable: _____

Carrier Address: _____

City:_____ State:_____ Zip:_____ Carrier Phone:_____

Patient Relationship to Insured:_____

Insured Name: _____
Last First M.I

Insured Address: _____ Apt #: _____

City:_____ State:_____ Zip:_____ Insured Phone: _____

Insured Date of Birth: _____/_____/_____ Insured Gender: _____

Insured Employer: _____

Additional Notes

_____

_____

_____

_____

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