New Patient Demographics

Last: _____ **First:** _____ **M:** _____

Today's Date: _____ **SS#**: _____ **Date of Birth**: _____

Sex: ☐ M ☐ F **Marital Status:** ☐ Never ☐ Married ☐ Remarried ☐ Separated ☐ Divorced ☐ Widowed **Veteran**: ☐ Yes ☐ No

Ethnicity / Race: ☐ White ☐ Hispanic ☐ African American ☐ American Indian ☐ Asian/Pacific Island ☐ Other

Address: _____ **City:** _____

County: _____ **State:** _____ **Zip:** _____

Phone: (H) _____ **(C)** _____ **(W)** _____

Visually Impaired? ☐ No ☐ Yes **Hearing Impaired?** ☐ No ☐ Yes

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Guardian / Responsible Party / Parent ☐ Same As Above

Name: _____ **Relationship:** _____

SS#: _____ **Date of Birth**: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (H) _____ **(C)** _____ **(W)** _____

Guardian / Responsible Party / Parent ☐ N/A

Name: _____ **Relationship:** _____

SS#: _____ **Date of Birth**: _____ **Address:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (H) _____ **(C)** _____ **(W)** _____

Who is the custodial parent/guardian of the client? _____

Emergency Contact

Name: _____ Relationship: _____

Phone #: (Home) _____ (Cell) _____

Referral Information
Reason for Referral: _____

Referred from: ☐ Clergy ☐ Court ☐ Mobile Crisis ☐ Family / Friend ☐ Public Health / Welfare Agency
☐ MD/NP Office ☐ Self ☐ Police ☐ School ☐ Community Mental Health Center
☐ Psychiatric Hospital ☐ General Hospital
