Alaska Psychiatric Concepts

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DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
IN CHILD, ADOLESCENT AND ADULT PSYCHIATRY

PATIENT INFORMATION

DATE _____

1. NAME _____
   LAST FIRST MIDDLE INITIAL
2. SOCIAL SECURITY NUMBER _____ DATE OF BIRTH_____
3. LEGAL GUARDIAN (If Minor) _____
   LAST FIRST MIDDLE INITIAL
4. MAILING ADDRESS _____

   CITY _____ STATE _____ ZIP _____ E-MAIL _____
5. MARITAL STATUS _____ DATE(S) OF MARRIAGE _____
6. NAME OF SPOUSE / PARTNER / BIOLOGICAL PARENTS _____
7. SIBLINGS and / or CHILDREN (Name / Age / Full / Half / Step) _____

   _____
8. EMPLOYER or SCHOOL (Position or Grade / Level) _____
9. PHONE (Home or Business) _____ MOBILE _____
10. ENCRYPTED VIDEOCONFERENCE APP(S) _____
11. SPIRITUAL PREFERENCE _____ 12. EDUCATION _____
13. PREVIOUS PSYCHIATRIC or OTHER MENTAL HEALTH CARE (attach pages) _____

    _____
14. PRIMARY CARE PHYSICIAN / PROVIDER _____
15. SPECIALTY CARE PHYSICIAN / PROVIDER _____

INSURANCE INFORMATION: PATIENTS WITH COMMERCIAL INSURANCE PAY WHEN SERVICES ARE RENDERED, AND USE THE RECEIPT PROVIDED TO FILE THEIR OWN CLAIMS PER COVERAGE. PLEASE SEE THE PRACTICE INFO AND OFFICE POLICIES ENDORSEMENT PAGE FOR MORE INFORMATION. THIS PRACTICE DOES NOT ACCEPT MEDICAID OR MEDICARE.

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