TRACY SAFF DOW Psy.D.
Doctor of Clinical Psychology

PATIENT INFORMATION SHEET
Please Print

Date: _____

PATIENT INFORMATION

Patient Name: _____ MI _____ M ____ F_____ Age _____DOB _____

SS# _____-_____-_____ Marital Status _____ Spouse Name _____

Patient Address: _____City _____Zip _____

Home Phone #: (_____) _____ Cell Phone #: (_____) _____

Patient Employer/School: _____School District: _____

Work Address _____ City _____

Occupation _____TEL # ()_____ EXT _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Phone: _____ Relationship: _____
_____

REFERRAL INFORMATION

Who Referred You? _____ TEL #: (_____)_____

❑ Friend or Other Patient ❑ Talk ❑ Doctor ❑ Counselor ❑ Administrator

❑ Company ❑ Pastor ❑ Church ❑ Other _____

May I send a thank you note to the referring source? ❑ Yes ❑ No

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IF PATIENT IS A CHILD:
Mother's Name: _____ DOB _____ Home #: (___)_____

Employer: _____ Work #: (____)_____

Father's Name: _____ DOB _____ Home #: ( )

Employer: _____ Work #: (____)_____

IF APPROPRIATE:
Which parent has legal custody of child?_____

Which parent does not live with child? _____

RESPONSIBLE PARTY:
Mr./Mrs./Ms./Dr. _____ Relationship to Patient _____

Address: _____ City _____ Zip_____

Home Phone #: (____)_____ Work Phone #: (____)_____ Ext_____

Employer _____ Occupation _____

I, THE UNDERSIGNED, ACCEPT FINANCIAL RESPONSIBILITY FOR PAYMENT OF ALL FEES AT THE TIME OF VISIT.

PRINT NAME _____

SIGNED _____ DATE _____