SOUTHERN CALIFORNIA PSYCHIATRIC GROUP, INC

PATIENT INFORMATION SHEET (PLEASE PRINT)

PATIENT NAME LAST _____ FIRST _____ MI _____

DOB _____ SEX ❑ M ❑ F LANGUAGE _____ Education _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____ PHONE _____

CELL _____ EMAIL _____

Consent - I consent use of ❑ SMS and Secure-Email for notification such as appointment reminders. I also understand that my mobile service provider may charge for each message I receive and that it is my responsibility for all such charges. I understand that text and email messages are not for emergency use and text messages are neither secure nor HIPAA compliant. **Initial** _____

MARITAL STATUS ❑ Unmarried ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Other _____

PROFESSION ❑ Student ❑ Employed ❑ Unemployed ❑ Housewife ❑ Retired ❑ Other_____

RACE✍ ❑ White ❑ Black ❑ Asian ❑ Pacific Islander ❑ Multi ❑ Declined ❑ Other _____

ETHNICITY✍ ❑ Hispanic/Latino ❑ Declined ❑ Other _____

REFERRAL NAME _____

FOR MINOR ❑ PARENT / ❑ GUARDIAN NAME _____

DOB_____ Patient Relationship _____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE NAME_____ ID _____

SUBSCRIBER RELATION ❑ Self ❑ Spouse ❑ Child ❑ Other _____ D.O.B._____

GROUP# _____SSN _____ EMPLOYER NAME _____

SECONDARY INSURANCE INFORMATION ❑ NONE Initial: _____

SECONDARY INSURANCE NAME_____ ID _____

SUBSCRIBER RELATION ❑ Self ❑ Spouse ❑ Child ❑ Other _____ D.O.B._____

GROUP# _____SSN _____ EMPLOYER NAME _____

EMERGENCY CONTACT

NAME _____PHONE# _____

ADDRESS: _____

Signature of Patient / Legal Guardian* _____ Date _____

Name (Printed) _____ Relationship to Patient _____

Patient Name (if different from that above) _____

*Except for birth parents, proof of legal guardianship that includes right to make medical treatment decisions for the patient above must be provided along with personal identification

Documentation Required for Patient File: ❑ Copy of Insurance Card both front and back

❑ Identification (parent/legal guardian's in case of Minor)

ITEMS MARKED ✍ ARE OPTIONAL