Comfort Arms NP Psychiatric Services PLLC
Edith Williams, PMHNP-BC

If patient is *YOUR CHILD*, please print *YOUR CHILD'S* information in *PATIENT SECTION* *PARENT* information (YOUR INFORMATION) goes in the *INSURED SECTION*

PATIENT INFORMATION

LAST NAME_____ FIRST NAME_____ SEX: M F

STREET _____ MARITAL STATUS: Sing Mar Sep Div

CITY, STATE, ZIP_____ BIRTH DATE_____ AGE___

HOME PHONE ( )_____ SS#_____

WORK PHONE ( )_____ EMPLOYER NAME_____

EMERGENCY CONTACT (name, phone)_____

REFERRED BY (name, phone)_____

INSURED INFORMATION PLEASE *COPY* INFORMATION FROM INSURANCE CARD

INSURANCE COMPANY _____ ID#_____

INSURANCE ADDRESS _____ PHONE ( )_____

PATIENT RELATION TO INSURED: *SELF SPOUSE CHILD*
IF OTHER THAN SELF, PRINT *INSURED* INFORMATION BELOW

NAME_____ **BIRTH DATE**_____ **SS#**_____

STREET_____ **CITY, ZIP**_____

NAME OF EMPLOYER_____

The following paragraphs (reverse side) list the most important office policies. PLEASE READ CAREFULLY. Your signature on the next page will indicate that any questions you had regarding the following information were answered to your satisfaction and that you are in agreement with those office policies that are applicable to you. You are encouraged to discuss any questions about policy. You are assured of receiving the best available treatment regardless of age, race, religion, sexual orientation or insurance type. **WELCOME**