TRIAD PSYCHIATRIC AND COUNSELING CENTER, PA

Name: First ______________________________ M.I. _______ Last ___________________________
Date of Birth : _______________________ Sex : Male/Female Marital Status: _______________
Social Security # : ______________________________
Street Address: ____
City: ____ State: _________________ Zip: ____________

PLEASE USE HOME # AS THE PHONE NUMBER YOU PREFER US TO CALL FOR APPT REMINDERS

Phone #: Home ______________________ Cell _______________________ Work _________________
Emergency Contact : ____________________________________ Phone # : _____________________
Relationship to Patient : ____

IF PATIENT IS A MINOR:

Mother's Name: ____
SS# (if Insurance Card Holder): ____
Phone # and Address (if different from above) : __________________________________
____

Father's Name: ____
SS# (if Insurance Card Holder): ____
Phone # and Address (if different from above) : __________________________________
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****PLEASE SUBMIT ANY CURRENT/UPDATED COURT ORDERS (OR) SPECIAL CUSTODY AGREEMENTS FOR PT TO ADHERE TO PRACTICE COMPLIANCE & HIPPAA GUIDELINES****

CIRCLE TO ADVISE IF ANY COURT ORDERS/CUSTODY AGREEMENT IN PLACE: YES NO

Primary Care Provider: ______________________________ Location: _______________________
Current Medication: (include over the counter) :
____
____
____

Current Local Pharmacy: _______________________________ Location: ______________________
Mail-In Pharmacy: ____

Medication Allergies:
____
____

Food Allergies:
____
____

Date: __________________________ **Completed by:** ____________________________________