

PATIENT DATA SHEET

<input type="checkbox"/> Initial	<input type="checkbox"/> Update
Name: _____	Account: _____
PATIENT INFORMATION	
Full Name: _____	
Last	First
Middle Initial	Suffix
Street Address: _____	
City / State / Zip: _____	
Phone Numbers: Cell: _____ Home : _____ Work: _____	
E-Mail Address: _____	
DOB: _____ Age: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Race _____	
Marital Status: _____ Employment Status: _____ Education: _____	
Source of Referral: _____	
EMERGENCY CONTACT INFORMATION	
Name: _____ Relationship: _____	
Address: _____ Phone: _____	
CONFIDENTIAL COMMUNICATION INFORMATION	
Do you have concerns with our office telephoning you at home or sending mail to your home? <input type="checkbox"/> Yes <input type="checkbox"/> No Patient Comments: _____	
ONLY if the answer is YES , complete the information below:	
1. May postcards/letters, which identify our facility (CMU Health Behavioral Medicine) be sent to this address: <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. What is the address for written confidential communication, if different than the address listed above? _____	
3. Is there an alternative phone number to be used for communication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
4. If YES to #3, what is the alternative telephone number? _____	
5. If YES to #3, what time(s) may we call? _____	
6. May our staff/facility leave a message at this phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. May this message include the name of our facility/staff? <input type="checkbox"/> Yes <input type="checkbox"/> No	
8. May we leave a blind message with our phone number only? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PERSONAL/LEGAL REPRESENTATIVE INFORMATION (IF APPLICABLE)	
Representative Name: _____ Relationship: _____	
Address: _____ Phone: _____	
Do you have proof of power of attorney / guardianship with you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Patient Signature: _____	Date: _____
<i>*Note: When a patient indicates that changes have occurred since his/her last appointment, then reassess the patient's preference for confidential communication.</i>	