



CONVENTIONS PSYCHIATRY & COUNSELING

4 SOUTH 100 RTE. 59 UNIT #6 NAPERVILLE, IL 60563

100 ILLINOIS ST, ST CHARLES, IL 60174

PHONE: 630/416-8289

FAX: 630/416-8306

PATIENT PERSONAL INFORMATION

PATIENT FULL NAME: _____

LAST

FIRST

M.I.

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE : _____

TELEPHONE : HOME: _____ WORK: _____ CELL: _____

S.S.# _____ DATE OF BIRTH: _____ AGE: _____ SEX: M__ F__

PATIENT'S EMPLOYER: _____ SCHOOL: _____

PARENT/GUARDIAN INFORMATION

IF CHILD, RESPONSIBLE PARENT/GUARDIAN: _____

RELATIONSHIP TO PATIENT: _____ S.S.# _____

STREET ADDRESS (IF DIFFERENT FROM ABOVE) _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: HOME: _____ WORK: _____ CELL: _____

FAMILY MEMBER INFORMATION

(FAMILY MEMBERS CURRENTLY LIVING IN SAME HOUSEHOLD):

	FIRST	LAST	SEX	RELATION	DATE OF BIRTH	SCHOOL
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____	_____

NAME/PHONE NUMBER OF INDIVIDUAL TO CONTACT IN CASE OF EMERGENCY: _____

NAME/CITY OF PHARMACY: _____ PHARMACY PHONE: _____

Who referred you to our office: _____ Primary Care Physician: _____

I hereby authorize CONVENTIONS PSYCHIATRY & COUNSELING to release to my insurance company or its representative, any/full information requested to include my diagnosis and records of my mental health treatment by this practice. I also authorize and direct my insurance company to pay directly to CONVENTIONS PSYCHIATRY & COUNSELING the amount due for treatment and/or services rendered. Patient/Insured agrees to pay for any/all services that are denied by the insurance company as not medically necessary, etc. Furthermore, I hereby give consent to CONVENTIONS PSYCHIATRY & COUNSELING to render mental health services deemed necessary to my minor child.

Patient signature: _____ Date: _____

Witness Signature: _____ Date: _____

Insured/Parent/Guardian Signature: _____ Date: _____