NYC Psychiatric
Nurse Practitioner Services, P.C.
Brooklyn, NY 11207

1035 Halsey Street, Garden Suite
Phone: 347-365-4421 Fax: 347-240-0730

Today's Date: _____

ADULT PATIENT INFORMATION:

Patient's Name: _____ Date of birth: _____ Age: _____

Street: _____ Soc. Sec. # _____-_____-_____

City: _____ State: _____ Zip: _____

Spouse's Name: _____

Cell:_____ Work phone: _____

Home phone: _____ Other contact:_____

Email address : _____@_____

In case of emergency or appointment concerns which number should be called ? _____

REFERRAL INFORMATION:

Referred by: _____ Service they provide: _____ Address:

_____

_____ Phone: _____ Fax: _____

Do you wish to provide consent so that treatment information/records can be obtained/shared: YES NO

May This person be contacted to thank for your referral? YES NO

What is the purpose of this referral/ reason for concern?

_____

PRIMARY CARE PROVIDER:

NYC Psychiatric
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Brooklyn, NY 11207

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Phone: 347-365-4421
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Internist: _____ Phone: _____

Address: _____

_____

_____

Other health care providers: _____

INSURED'S INFORMATION:

Name: _____ Date of birth: _____

Soc. Sec. #: _____

Address: _____

_____

_____

Employer: _____ Work: Phone: _____

Employer address: _____

_____

ADDITIONAL INSURED'S INFORMATION:

Name: _____ Date of birth: _____

Soc. Sec. #: _____

Address (if different from patient): _____

_____

_____

Employer: _____ Work: Phone: _____

Employer address: _____

_____

I UNDERSTAND THAT ALL CANCELLATIONS REQUIRE 24 HOURS NOTICE OR MISSED APPOINTMENTS WILL BE BILLED TO THE PATIENT/GUARDIAN AT THE CURRENT PRIVATE RATE. Unpaid accounts sent to collections will have a 25% added surcharge. I have read and understand these terms. Signature: _____