SUGI
PSYCHIATRY
& WELLNESS

PATIENT DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____
Sex: _____ Gender: _____ Marital Status: _____ Preferred Language: _____
Home Address:
_____
Email: _____
Home Phone: _____ Cell Phone: _____

Primary Care Physician Name and Phone Number: _____
Previous Outpatient Psychiatrist Name and Phone Number: _____
Previous Outpatient Therapist Name and Phone Number: _____

Are you **currently** receiving therapy or mental health services at another clinic? Is so, please list the agency and/or provider information here: _____

Primary Insurance Name: _____
Insurance ID#: _____ Group#: _____
Insurance Address: _____
Insurance Phone: _____
Primary Insured's Name and Date of Birth (if other than patient):
_____

Secondary Insurance Name: _____
Insurance ID#: _____ Group#: _____
Insurance Address: _____
Insurance Phone: _____
Primary Insured Name and Date of Birth (if other than patient):
_____

Preferred Pharmacy (address and phone number):
_____

Do you have any allergies to any medications? If so, please list below:
_____

Please list all medications you are currently taking:

Medication Name	Dose	Frequency

Please list all previous psychiatric medications:

Medication Name	Highest Dose	Reason Stopped

Have you ever been hospitalized in a psychiatric facility? ☐ Yes ☐ No

Reason for Admission:

☐ Depression or Suicidal Ideation ☐ Mania ☐ Self-Harm ☐ Schizophrenia or Psychosis

☐ Other (Please List): _____