4016 Barrett Dr, Suite 104 Raleigh, NC 27609
919-824-9102

Adolescent Biopsychosocial Face Sheet

Patient Information

Name - Last: _____ First: _____ Middle: _____

Address - Street: _____ City: _____ State: __ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

Date of Birth: _____ Age: __ Gender: __

Social Security #: _____ Driver's License #: _____

Occupation: _____ Employer: _____

Patient Medical and Personal History

Allergies: _____

Medications: _____

Known Medical Conditions: _____

Previous Surgeries/Illnesses; Include Dates: _____

Primary Doctor - Name: _____ Phone: _____

Street: _____ City: _____ State: __ Zip: _____

Psychiatrist - Name: _____ Phone: _____

Street: _____ City: _____ State: __ Zip: _____

Parent Information

Name - Last: _____ First: _____ Middle: _____

Address - Street: _____ City: _____ State: __ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

Occupation: _____ Employer: _____

In Case of Emergency - Name: _____ Relationship: _____

Phone: _____

Responsible Party Information

** Only provide information in this section if the responsible party is someone other than the parent.

Name - Last: _____ First: _____ Middle: _____

Address - Street: _____ City: _____ State: __ Zip: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Email address: _____

Relationship To Patient: _____

Acknowledgement

I understand that I am required to give Dr. Beverly Simmons or Raleigh Psychotherapy, PLLC 24 hours notice if I need to cancel an appointment, and I understand that Raleigh Psychotherapy, PLLC will bill me for the full fee if I fail to give her the required notice.

_____ _____

Signature Date