Southern Psychiatry

Patient Demographic Sheet - Elizabeth Dukes, LPC

Full Name: (*Last, First, MI)* _____
Preferred Name: _____
Birth Date:_____ Gender:_____ Race:_____ Marital Status:_____
Email address*: _____
Phone:_____ Appointment reminder: Text Msg Email
Address: _____
City: _____ State: _____ Zip:_____
Employer: _____ Phone: _____

Emergency Contact Information:

Name: _____ Phone: _____
Relationship: _____
Does the provider have permission to share necessary information with this contact in a situation s/he deems an emergency?
YES NO Initials_____

(Guarantor) Financially Responsible Party's Information

Full Name:(*Last, First, MI)* _____
Birth Date:_____ Gender:_____
Address: _____
City: _____ State: _____ Zip:_____
Phones: _____
Relationship to patient: Self Spouse Parent Other:_____

Insured's Information**

Primary Insurance Co: _____
Insurance ID:_____
Group ID:_____
Name:_____
Birth Date:_____
Phone:_____
Relationship to patient:_____

Does the patient have a second insurance carrier? YES NO

If so, please provide this information.

*Email is only used to send patients receipts, statements for insurance reimbursements, and appointment reminders. **Patients under 18 should provide the email address of a parent/guardian.**

**Insurance information is only documented in regards to an insurance carrier requesting medical records to confirm services rendered. Insurance carriers could potentially do this if the invoice was submitted to the carrier and they are attempting to process a reimbursement to the patient.

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