Nurse Practitioner of Erie Niagara Psychiatry PLLC

**PATIENT INFORMATION SHEET**

NAME:_____ MAIDEN NAME:_____ DATE OF BIRTH:_____

ADDRESS: _____

CITY: _____ STATE:_____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

WHO CAN WE CONTACT IN CASE OF EMERGENCY? : _____
RELATIONSHIP: _____

**MEDICAL INFORMATION**

Primary Care Physician: _____
Address: _____
Phone number: _____
Insurance: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____

PHARMACY: _____
Address: _____
Phone number: _____

***A 24-hour cancellation notification is required. There will be a cancellation fee charged for appointments cancelled without at least 24 business hour notice. This fee is NOT billable to any insurance carrier.**

****PLEASE NOTE: You will be held liable for any collection costs and/or attorney fees in the event those services are needed to collect this debt.**

***** By signing this form you are indicating that you have read and understand the accompanying office policy.**

**Signature: _____ Date:_____**