**SAN ANTONIO FAMILY PSYCHIATRY(SAFP)**
**Psychiatry for Adults, Adolescents and Children**
16007 Via Shavano, Ste. 102
San Antonio, TX 78249
Tel. (210) 492-1666
Fax. (210) 615-9400

PATIENT INFORMATION

Patient Name: _____ Medication Allergies (list): _____
First Middle Last
Street Address/Apt. #: _____ City: _____ State: ____ Zip Code: _____

Home Phone: (_____) _____Work Phone: (_____) _____ Cell Phone: (___)_____ Age: ____

Date of Birth: _____ Sex: (circle one) Male/Female Social Security Number: _____

Name of Referring Physician, Therapist or other source: _____ Telephone: (____) _____

Marital Status: Single Married Divorced Separated Widowed Patient is: (circle, if applicable) Employed Student

If Patient is a Student, Name of School:_____Telephone: (____) _____

If Employed, Employer_____ Occupation: _____Work Address:_____

IF PATIENT IS A CHILD: Father's Name: _____ Work Phone: (____)_____ Employer: _____

Mother's Name: _____Work Phone: (____)_____ Employer: _____

IF PATIENT IS MARRIED: Spouse's Name: _____Work Phone: (____)_____ Employer: _____

RESPONSIBLE PARTY: Name: _____ Address: _____

Relationship: _____ Social Security Number: _____ Employer: _____

Driver's License Number of Responsible Party:_____ State of License: _____ DOB: _____

Home Phone: (____)_____ Cell Phone: (____) _____ Work Phone: (____) _____

IN CASE OF EMERGENCY CONTACT: Name: _____ Phone: (____)_____ Relationship: _____

Pharmacy Name, Location and Phone Number:_____

INSURANCE INFORMATION:
**Insurance Company**: _____ Policy/ID Number: _____

Group/Policy Number: _____ Name of Policyholder/Insured's Name: _____

Insured's Date of Birth: _____ Relationship of Insured to Patient: _____

**CANCELLATION POLICY:** YOU WILL BE CHARGED THE FULL AMOUNT OF THE OFFICE VISIT FOR APPOINTMENTS NOT CANCELLED AT LEAST **ONE BUSINESS DAY IN ADVANCE**. For example, an appointment for Monday needs to be cancelled by the Friday before, during *normal business hours*. Your insurance company will not cover a missed appointment charge and you are responsible for payment.

I, (Print Name)_____ hereby authorize my insurance company benefits to be paid directly to ,SAFP, realizing I am responsible for payment of deductibles, co-pays and any non-covered services. Additionally, I hereby authorize the release of pertinent medical information to insurance carriers. I have completed this form accurately and the information I have provided is correct, to the best of my knowledge.

_____ _____ _____
**Signature** of Financially Responsible Party **Print** Name of Responsible Party Date