



Elizabeth O. Dania

NP in Psychiatry, PLLC

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Psychiatric Mental Health Services
191-15 115TH Avenue, Saint Albans, NY 11412
Phone: (516) 234-6805 Fax: (917) 909-6150
Email: edania84@gmail.com

Client Information Form

(If you have been a patient here before, please complete only the information that has changed.)

Today's Date: _____

A. Identification

Full Name: _____

Date of Birth: _____ Age: _____

Nicknames or Aliases: _____

SSN (Optional): _____

Home Address: _____

Apartment #: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Email Address: _____

Preferred Method of Contact: _____

Restrictions regarding calls/emails/messages: _____

B. Referral Information

Who referred you to this practice? _____

Phone Number: _____

Address: _____

May we thank this person for the referral? Yes No

How did they describe how I might be of help?

C. Religious and Racial/Ethnic Identification

Religious Affiliation:

Protestant Catholic Jewish Islamic Buddhist Hindu Other: _____

Level of Involvement: None Some/Irregular Active

How important are spiritual concerns in your life? _____

Ethnicity/National Origin: _____

Race: _____

Other important ways you identify yourself: _____

D. Medical Care

Primary Care Provider/Clinic: _____

Phone Number: _____

Address: _____

May we contact your medical provider for coordination of care? Yes No

E. Employment Information

Employer: _____

Employer Address: _____

Work Phone Number: _____

Other Contact Method: _____

Any restrictions regarding contact? _____

F. Emergency Contact

Emergency Contact Name: _____

Phone Number: _____

Relationship: _____

Address: _____

Significant Other / Nearest Relative (not living with you): _____