PSYCHIATRY (713) 464-4455

WILLIAM K. DRELL, M.D.
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SUITE 283
HOUSTON, TEXAS 77024

This information is necessary to confirm your appointment with Dr. Drell. Dr. Drell will not be your psychia- trist until your first visit, when he actually evaluates you and determines if he can be of assistance.

NEW PATIENT INFORMATION RECORD

DATE:_____

Please print or write legibly

Patient's Name_____**Social Security Number**_____

Age_____**Date of Birth**_____**Marital Starus: S ____M____DIV___ SEP___WID____**

Home Address_____**Apt. No.**_____ **Home Phone**_____

City and State_____**Zip Code**_____ **Cell Phone** _____

May we call you at home? _____ On your cell phone?_____May we leave messages on either?_____

Email address_____ **Can we leave confidential information?**_____

Employer/Company Name_____**Occupation**_____**Work phone**_____

Employer/Company Address_____

May we call you at work?_____**May we leave messages on your work voice mail?**_____

Spouse/Nearest Relative_____**Relationship**_____

Address_____**Phone**_____**Work phone**_____

At times, we may need to leave a message regarding your appointment, medication or to discuss your treatment with your family, therapist, employer, etc. Please list by names with whom we may share this type of information:

_____

_____

Referred by_____**Address**_____**Phone**_____

Please acknowledge giving us permission to release information to your referral source or other individuals by signing your name here:_____

Patient or Guardian Signature

IF THE PATIENT IS A MINOR OR STUDENT

Person responsible for billed amount_____**Relationship**_____

Address_____**City/State**_____**Phone**_____

Employer and Business address_____**Work Phone**_____