81 Holly Hill Lane; 2nd floor
Greenwich, CT 06830
(203) 321-5063 or (203) 769-1312

Tarique Perera, MD
Joseph Deltito, MD
Erica Saypol, PhD
Lisa Fraidin, PhD

Patient Information

Name ____________________________________ **Date** ____________________

Address ____

City/State/Zip ____

May we write you at your home address? Yes ___ No ___

Date of Birth _________________

Occupation _________________ **Employer or School**___________________

Gender _________________ **Marital Status** ________________________

Home Ph. ( )______________ May we leave detailed messages? Yes___ No__

Cell Ph. ( )______________ May we leave detailed messages? Yes___ No__

Work Ph. ( )______________ May we leave detailed messages? Yes___ No__

Which is your preferred contact number? Home___ Cell___ Work___

Fax Number ( )__________________ May we send you faxes? Yes___ No__

Email Address ____

May we email you with information? Yes___ No___

What pharmacy do you use? ____

Patient Code: ________

Insurance Information

Primary Insurance Carrier ______________________ Phone (   ) __________

Insurance ID ____________________ Group/Plan# _____________________

Insured Name____

Insured Employer ____

Insured DOB ______________________________ Gender ________________

Secondary Carrier __________________________ Phone (   ) ___________

Group/Policy# _______________________ Patient ID# __________________

Insured Name ____

Insured Employer ____

Insured DOB ____

Emergency Contact

Name____

Relationship to Patient____

Address ____

City/State/Zip ____

Home Phone (   )_______________ Cell Phone (   )__________________

Referred by

Name ____________________________ Phone (   )___________________________

Address ____

City/State/Zip ____

Patient Code: ________

Medical Information

Primary Care Doctor____________________ **Phone (   )** __________________

Psychiatrist___________________________ **Phone (   )** __________________

Current Medication(s) | **Dosage/Frequency**

_____________________________ | ___________________________

_____________________________ | ___________________________

_____________________________ | ___________________________

_____________________________ | ___________________________

_____________________________ | ___________________________

Past/Present Medical Conditions____

____

____

Have you been in psychotherapy before? Yes___ No___

If yes, when ____

Please list previous therapist(s) name(s), date range, reason for treatment, and reason for termination:

Name	Date Range	Reason for Treatment	Reason for Termination

Reason for today's visit?____

____

____

Patient Code: ________

Highest Level of Education Completed ___________________________________

Please list the age of each parent (or age when deceased)

Mother___ Father___

Do you have siblings? Yes___ No___ If so, please list gender and age of each:

____

____

Have any of the following relatives had psychological difficulties (whether or not they received treatment)?

Relative	Yes / No	Type of Problem (e.g., anxiety, depression, bipolar disorder, schizophrenia, etc.)
Mother		
Father		
Siblings		
Aunts/Uncles		
Cousins		
Grandparents		

Patient Code: _________