RICARDO BIERRENBACH, MD
PSYCHIATRY

Patient Information

Last Name:_____ First Name:_____
Middle Initial:_____ D.O.B.:_____
Street Address: _____
Suite/Apt#: _____
City: _____ State: _____ Zip Code: _____
Telephone
Home: _____
Cellular: _____
Social Security #: _____
Email:_____ Patient Portal- please circle Yes or No
Married: _____ Single: _____ Widowed: _____ Divorced: _____
Occupation: _____ Employer: _____
Work Address: _____
City: _____ State: _____ Zip Code: _____
Work Phone: _____
Emergency Contact
Name: _____
Relation to Patient: _____
Phone: _____

***Please be advised due to an increase in NEW** appointments not being cancelled per our 24 hour policy. A valid credit card will be required to hold all NEW** patient appointments**

What is the reason for your visit today?

_____
_____
_____
_____

Have you or an immediate family member been treated for the following? (please circle)

High Blood Pressure	Heart Disease	Asthma
Diabetes	Cancer	Thyroid Disease
High Cholesterol	Anemia	

Do you smoke? Never_____ Occasionally_____ Often_____
Do your drink? Never_____ Occasionally_____ Often_____

List any known drug allergies:

_____
_____

Please list all known medical conditions:

_____
_____
_____
_____

Please list all medication that you are currently taking:

_____
_____
_____
_____

Who can we thank for referring you to our office?

_____
_____

**New Patient- No prior office visits ,or due to elapsed time from past visits Dr Bierrenbach considers initial evaluation necessary.