BIOLOGICAL PSYCHIATRY CENTER, P.C. **PATIENT DEMOGRAPHIC UPDATE FORM**

DATE: ______/______/______ **PATIENT NUMBER:** ________________

Last Name:________________________________ **First Name**:______________________________ **Middle Name**:____________

Address:____**City**:__________________ **State**:_______ **Zip code**:____________

Cell #: (_____)_______________ **Home #**: (_____)_______________ **Alt #**: (_____)_________________

Our office utilizes HIPAA compliant programs to send appointment links, appointment reminders, payment links and payment reminders as a way to communicate with patients. May we text you at the number listed above? Yes / No

E-Mail: ________________________ **Date of Birth:** _______ /_______ / _______ **Social Security #:** ______/______/_______

Employed: Yes / No **Employment Status:** Part-Time / Full-Time / Retired / Other: ___________ **Employer**:_____________________

Family Doctor: __________________________ **Phone#:** (_____)_______________ **Address**: _______________________________

Neurologist: ____________________________ **Phone#:** (_____)_______________ **Address**: _______________________________

Mental Health Therapist:______________________________ **Phone#:** (_____)_________________

REQUIRED FOR MINORS:

Fathers Name: __________________________ **DOB:** _____/_____/______ **Cell#:** (____)_____________ **Home#**: (___)__________

Mothers Name: __________________________ **DOB:** _____/_____/______ **Cell#:** (____)_____________ **Home#**: (___)__________

School Name: _________________________________ **Phone#:** (_____)____________ **Counselor**: ___________________________

Address: ____ **Accommodations in Place:** IEP / 504 / Other:__________________

INSURANCE INFORMATION:

Email Copy of ID and Cards to: forms@bpcpc.com

Primary Insurance: Policy Holder Name:____ **Policy Holder DOB:**_____/____/_____

Name of Insurance Carrier:_____________________________ **ID#:** ___________________________ **Grp#:** _________________

Secondary Insurance: Policy Holder Name:____ **Policy Holder DOB:**_____/____/_____

Name of Insurance Carrier:_____________________________ **ID#:** ___________________________ **Grp#:** _________________

Tertiary Insurance: Policy Holder Name:____ **Policy Holder DOB:**_____/____/_____

Name of Insurance Carrier:_____________________________ **ID#:** ___________________________ **Grp#:** _________________

PHARMACY INFORMATION:

Mail Away Pharmacy Name:	**Address:**	**Phone: ( )**
Local Pharmacy Name:	**Address:**	**Phone: ( )**

FORMS GIVEN BY BPC STAFF: (Annually)

- Patient-Provider Partnership Agreement: _______ (Please Initial) / Financial Policy: __________ (Please Initial)

- HIPAA Privacy Policy: __________ (Please Initial) / Telehealth Consent of Treatment: ___________ (Please Initial)

EMERGENCY NOTIFICATION - In Case of Emergency Notify:

Name: ____ **Relationship**: _____________________________________

Home #: (_____)__________________ **Cell #**: (_____)__________________ **Alt #**: (_____)_____________________________

I hereby give consent to contact the above-named person if I require emergency care / hospitalization.

____ ____________________

Patient / Guardian Signature **Date**