**STEPHANIE B. LEVEY, PH.D.**
**125 EAST 84TH STREET, SUITE 1A**
**NEW YORK, NY 10028**
**(212) 203-6710**

# PATIENT INFORMATION FORM

Today's Date: ______________________________________________________________

Full Name: ________________________________________________________________

Home Address: _____________________________________________________________

Referred By: _______________________________________________________________

Occupation/Employer: ________________________________________________________

Work Address: ______________________________________________________________

Student? No ____ Yes (name of school) ______________________________________

Phone: Home ________________________________ Cell ____________________________

Work _____________________________________ Other ___________________________

Best number and time to contact you: _________________________________________

Email(s): ___________________________________________________________________

Birthdate: ___________________________ Age_______ SS# _______________________

Primary Care Physician: ______________________________________________________

Address: ___________________________________ Phone: ______________________

Other relevant Physician Information (Psychiatrist, OB/Gyn, Neurologist, etc.):

Name: _____________________________________ Phone: ______________________

Persons to be contacted in the event of an emergency:
Name: ________________________________Relationship: ____________ Phone: ______________
Name: ________________________________Relationship: ____________ Phone: ______________

Primary reason for seeking consultation:

_____________________________________________________________________________