IOWA PSYCHIATRY
2327 70th Street | Urbandale, Iowa 50322
P: (515) 270-2242 | F: (515) 777-1950

PATIENT INFORMATION

Date:_____

First Name:_____ MI:_____ Last Name:_____

Social Security Number (Optional):_____ Date of Birth:_____

Sex: ☐ Male ☐ Female

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ Email Address:_____

Appointment Reminders Preference: ☐ Call ☐ Text ☐ Email

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Significant Other's Name, if applicable:_____

Emergency Contact Name:_____ Phone:_____

Relationship to Emergency Contact:_____

Primary Care Provider:_____

Therapist:_____

Pharmacy:_____ Location:_____

Employment Status: ☐ Unemployed ☐ Student ☐ Full-Time

☐ Part-Time ☐ Self-Employed ☐ Retired

Name of Employer: _____

INSURANCE INFORMATION

Name of Primary Insurance Carrier:_____

Subscriber ID#:_____ Group #:_____ Relationship:_____

Subscriber Name:_____ DOB:_____

Name of Secondary Insurance Carrier:_____

Subscriber ID#:_____ Group #:_____ Relationship:_____

Subscriber Name:_____ DOB:_____

GUARANTOR INFORMATION (who is responsible for the patient's medical bill):

Name:_____ SSN:_____

Relationship to Patient:_____ M / F DOB:_____

Address:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Employer:_____

I authorize Iowa Psychiatry, LLC to:

- Furnish my insurance company with any/all information requested concerning my present claim(s), including, but not limited to, diagnosis information pertaining to mental health, substance abuse, HIV/AIDs, and genetic testing
- Bill my insurance company and accept payment from the company on my behalf for all services from time to time relating to my case
- Charge the credit card on file for any appointment cancellations without 24-hour notice or no showed

I acknowledge that I am responsible for all charges not covered by my insurance. I understand that failure to resolve any outstanding balance may result in my account being referred to a collection agency if it remains delinquent.

Patient signature:_____

Date:_____