Balanced Minds PLLC
PATIENT INFORMATION

Date:____/____/____

Last Name:_____ First Name:_____ M Initial:_____

Nickname:_____ Age_____

Sex (circle): M F Soc. Sec #:_____-____-_____ DOB: _____/____/____ Marital Status: _____

Race (Ethnicity):_____ Language spoken at home:_____

Home Address:_____ City:_____ State:____ Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Email: _____@_____ Best way to contact you:_____

Employer:_____ Occupation:_____

Who referred you?:_____ Phone: (___)_____ Fax#: (___)_____

Address:_____ City:_____ State:____ Zip:_____

I would like my referral source contacted about my psychiatric care (circle) Yes No

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CAREGIVER INFORMATION (LEGAL GUARDIAN IF CHILD/ADOLESCENT)

Name:_____ Age:_____ Sex (circle): M F

Relationship with patient:_____

Address (if different than above): _____City:_____ State:____ Zip:_____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Email: _____@_____ Best way to contact you:_____

Employer:_____ Occupation:_____

BALANCED MINDS
Zuraima Caldera, M.D.
Child and Adolescent & Adult Psychiatry

Balanced Minds PLLC
5524 Bee Cave rd.
Suite E3
Austin, TX 78746
Phone: 512 851 1220

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Name:_____ Age:_____ Sex (circle): M F

Relationship with patient:_____

Address (if different than above): _____City:_____ State:____ Zip:_____

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Email: _____@_____ Best way to contact you:_____

Employer:_____ Occupation:_____

EMERGENCY INFORMATION:

Emergency Contact:_____ Relationship:_____ Phone:(___)_____

Drug Allergies:_____

MEDICAL INFORMATION:

Primary Care Doctor: _____ Phone: (___)_____ Fax#: (___)_____

Address:_____ City:_____ State:____ Zip:_____

I would like my primary care physician contacted about my psychiatric care (circle) Yes No

Preferred Pharmacy: _____ Phone: (___)_____ Fax#: (___)_____

_____ _____

Patient's signature Date

_____ _____ _____

Legal Qualified Representative Relationship Date