HOUSTON WEST TMS

William K. Drell, MD
902 Frostwood Dr., Suite 283
Houston, TX 77024 | (713) 464-4455

NEW PATIENT INFORMATION RECORD

Patient details, address, payment information, and contact preferences

This information is necessary to confirm your appointment with Dr. Drell. Dr. Drell will not be your psychiatrist until your first visit, when he evaluates you and determines whether he can be of assistance.

Please print or write legibly, or complete the fillable fields.

Patient details

Patient's name

Date

Age

Date of birth

Marital status (S / M / DIV / SEP / WID)

Home address

Apt. no.

Home phone

City and state

ZIP code

Cell phone

Credit card information - provide directly to the office

Name on credit card

Credit card number

Expiration date (MM/YY)

Security code (paper / in-office only)

Billing ZIP code

Office use: remove the payment section before retaining the patient record. Do not retain the security code after payment authorization. Do not email or upload completed payment details.

Contact preferences

May we call you at home? (Y/N)

May we call your cell? (Y/N)

Leave messages on either? (Y/N)

Email address

May we leave confidential information? (Y/N)

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Employment, contacts, information-sharing permissions, and billing responsibility

Employment information

Employer / company name

Occupation

Work phone

Employer / company address

May we call you at work? (Y/N)

May we leave messages on work voicemail? (Y/N)

Spouse / nearest relative

Spouse / nearest relative

Relationship

Phone

Address

Work phone

Information-sharing permissions and referral

At times, we may need to leave a message regarding your appointment or medication, or discuss your treatment with your family, therapist, employer, etc. List the names of people with whom we may share this information:

Names of individuals with whom information may be shared

Referred by

Referral address

Referral phone

Please acknowledge giving us permission to release information to your referral source or other individuals listed above by signing your name below.

Patient or guardian signature

Date

If the patient is a minor or student

Person responsible for billed amount

Relationship

Address

City / state

Phone

Employer and business address

Work phone