Arian S. Elfant, Ph.D.
8438 Oak Street, Suite B
New Orleans, Louisiana
(504) 319-6800

CLIENT INFORMATION *(please print)*

Full Name:

_____
First Middle Last

Age: _____ **Date of Birth**: _____

Local Address:

_____

CONTACT INFO:

Local Phone: _____

Other Phone: _____

Work Phone: _____

EMAIL ADDRESS: _____

Employer/Place of Employment: _____

Your Position:_____

Address:_____

Who may I thank for referring you:

_____

Emergency Contact:

Name: _____

Phone: _____

Address: _____

Briefly describe why you are seeking services at this time

_____

_____

Primary Care Physician:

_____

Telephone:

_____

List any major illnesses or medical conditions:

_____

Treating Physicians:

_____

_____

List all medications and medical dosages:

_____

_____

Please use whatever space you need to note any additional information you feel is pertinent to your care. (feel free to write on back of page)

CONTACT INFORMATION

Unless you indicate otherwise, should I need to contact you or your child regarding scheduling conflicts, etc. that may arise during the course of treatment, I will contact you directly via telephone. I also wish, however, to protect your confidentiality. Using the checklist below let me know if it is okay to contact you in the following ways. If you have questions or concerns about how I may contact you, please let me know.

	(Circle if okay)	
Phone Numbers:	Okay to Call?	Okay to Leave a message?
Home: _____	Y	Y
Work: _____	Y	Y
Cellular:_____	Y	Y
Other: _____	Y	Y

Dr. Elfant may send correspondence to the following address:

_____

_____

My signature below indicates that I understand and agree with the statements above.

Signature _____