**Mark W. Wilson, MD**

**Executive Medical Director**

**Center for Wise Mind Living**

Wise Mind Living Psychiatry

250 West 54th Street, Suite 406

New York, New York 10019

Contact Information Form

# Client name:

# Date of birth:

# Name(s) of caregiver(s), for youth clients:

# Address(es):

# Home address (for separated/divorced parents of youth clients, please list both addresses):

# Billing address, if different:

# Number(s):

# Home number(s):

# Mobile number(s):

# Work number(s):

# Fax number(s):

# Other number(s):

# Email address(es):

# Name(s)/number(s) of emergency contact(s):

# Therapist name(s)/contact information, if applicable:

# Name(s) of medical provider(s)/contact information, if applicable:

Pharmacy name, number, and address:

# Insurance:

# Name of insurance:

# Insurance ID number:

# Insurance group number:

# Insured name, if different from client:

# Insured’s date of birth, if different from client:

# General insurance phone number:

# Prescription ID number, if different from insurance ID number:

# Insurance phone number for “prior authorization of medications” (for doctors):

# School, for youth clients:

# Name of school/contact information:

# Names of key school staff and contact information:

# Grade, for youth client:

# Classification, if applicable:

# Names of other relatives or roommates in household:

# Current Weight:

# Current Height: