

Aurora Psychiatric Associates, PLLC
120 Greenwich Avenue, 3rd Floor
Greenwich, CT 06830
Phone: 937-604-2939

Name of Patient _____

Address _____

City _____, State _____, Zip Code _____

Home Phone _____, Cell Phone _____

Email _____

If applicable - Parent's Cell Phone: _____

If applicable - Parent's Email _____

Preferred Pharmacy _____

Date of Birth _____, Allergies _____

Sex Assigned at Birth _____

Gender: female male. non-binary. gender fluid other

Pronouns: _____

Referred by _____

Emergency Contact:

Name _____ Relationship _____

Home Phone _____ Cell _____, Work _____

Individual Financially Responsible for This Account:

Name _____, Relationship _____

Address _____

City _____, State _____, Zip Code _____

Home Phone/Cell/Work Phone _____

Signature of Responsible Party _____

If the responsible party is not present at the initial visit to accept financial responsibility, they must contact the office directly and until such time, the patient, parent or guardian present at time of appointment will be responsible for payment of charges.