



Patient Information and Billing Form

Welcome to the Psychiatric Center of Katy, office of Christell Lara, M.D., P.A. We look forward to working with you. Please fill out the following form so we may better serve you and assure you are taken care of in a timely manner. All information is confidential. Please print.

Patient Name: _____ Date of Birth _____

Address: _____ City: _____ State _____ Zip _____

Home phone: () _____ Work Phone: _____ Ext. _____

Cell Phone: () _____ E-mail address: _____

Marital Status: Married _____ Divorced _____ Single _____ Widowed _____ Minor _____

Patient's or parent's employer: _____ Occupation: _____

Spouse's or parent's name: _____

How did you hear about us? Friend _____ Dr. _____ Therapist _____ Internet _____

Emergency contact (not living with you): _____ Phone # () _____

Insurance Policy Information for Value Options Patients:

Policy holder: _____ Policy holder DOB: _____

Policy holder's social security #: _____ Employer and work phone # _____

ID or Policy # _____ Group # _____