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**Dilek Wise, PhD, LMFT**  
(713) 294 8090

### Personal Data Record

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
SSN: \_\_\_\_\_ TXDL: \_\_\_\_\_  
Employer / School: \_\_\_\_\_  
Current Position / Degree: \_\_\_\_\_  
Referred to our Office by: \_\_\_\_\_

**Emergency Contact** (please put someone other than your spouse if you are coming for couples therapy)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Your Physician / Psychiatrist's** Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medications / Dosages: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information** (if applicable)

Person Responsible for the Account: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Initial Authorization / Pre-Certification #: \_\_\_\_\_  
Claims Address: \_\_\_\_\_  
Insurance Phone (s): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_