CHRISTOPHER R. THOMPSON, M.D., P.C.
CERTIFIED BY THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY IN GENERAL PSYCHIATRY,
CHILD & ADOLESCENT PSYCHIATRY, AND FORENSIC PSYCHIATRY, AND BY THE AMERICAN BOARD OF ADDICTION MEDICINE

# PATIENT INFORMATION FORM

NAME: _____

PARENTS' NAMES (*if applicable*): _____

PATIENT'S DATE OF BIRTH: _____ /_____ / _____

HOME ADDRESS: _____

CITY: _____STATE: _____ZIP: _____

CELL PHONE: (_____) _____

WORK PHONE: (_____) _____

E-MAIL ADDRESS(ES): _____

## PAYING BY CREDIT CARD

**(SIGNATURE AUTHORIZES RECURRING MONTHLY CHARGE OF BALANCE DUE)**

(*circle):* Visa MC AmEx

CC #: _____—_____—_____— _____

EXP. DATE: _____ / _____ **CVV:** _____

NAME (*as it appears on card*): _____

BILLING ADDRESS OF CARD (*"same" if it is HOME address above*):

_____

CITY: _____ STATE: _____ZIP: _____

SIGNATURE: _____

10850 WILSHIRE BOULEVARD, SUITE 850, LOS ANGELES, CA 90024
PHONE (310) 470-7064 FAX (310) 470-7141 EMAIL CHTHOMPSON@MEDNET.UCLA.EDU