BEHAVIORAL HEALTH NEW PATIENT APPLICATION

Provider Preference?_____

PLEASE PRINT Date:___/___/____

Last Name:_____ First Name: _____D.O.B: ___/___/____ SSN:____-____-____

Preferred Language: _____ Ethnicity (optional) : Hispanic or Latino? Y N

Race: African American American Indian or Alaskan Native Asian Native Hawaiian or other Pacific Islander White

Sex: M F X Guardian Name (If patient is a minor):_____

Street Address:_____ Mailing Address:_____
City:_____ State:_____ Zip:_____

Home Phone:_____ Mobile Phone:_____ Work Phone:_____

Email Address:_____

Person Responsible for Bill:_____ Responsible Party SSN:_____-____-_____

Relation to client: self or other _____Employed by:_____ Occupation:_____

Do you have Medical Insurance? If yes, please fill in the following information:

Name of Primary Insurance:_____ ID#:_____ Group #:_____
Subscriber's Name:_____ D.O.B: ___/___/____

Insurance Address:_____ City:_____ State:_____ Zip:_____

Name of Secondary Insurance: _____ ID#:_____ Group #:_____

Subscriber's Name:_____ D.O.B: ___/___/____

Insurance Address:_____ City:_____ State:_____ Zip:_____

This information is required by HIPAA

In case of emergency, who should be notified?_____
Relationship:_____ Home Phone:_____ Mobile Phone:_____

Primary Care Provider/Clinic:_____

Pharmacy:_____

Have you been seen by our clinic before? Y N How did you learn about our office? _____

OFFICE USE ONLY

PMP review Accepted? Yes- Create chart No- Denial Letter sent_____

Contacted for appt _____ date, time

2nd Call_____ NO RESPONSE ? Close 1 week later

INTAKE SCHEDULED_____

Patient Health Questionnaire

Date:_____Name:_____

Date of Birth:_____

What are you requesting to be seen for? Have you been seen for this issue before?

Issue/Diagnosis (if known)_____ Year of Diagnosis_____

Name of Previous Mental Health Provider_____

Current Therapist _____

Have you been hospitalized in the past for mental health issues?_____ When? _____

Where?_____

Current Medications and dosages?

NAME OF MEDICATION	DOSE	PROVIDER	WHAT FOR?

How long have you been taking these?

Past Mental Health Medication

NAME OF MEDICATION	DOSE	PROVIDER	WHAT FOR? Stop date?

Do you have any major chronic medical issues? (ie, heart condition, seizure, diabetes, kidney or liver issues, etc)_____

Medication Allergies_____

Do you have a preferred name/nickname?_____

Is there any important information you would like us to know as we consider you for our services?

_____
_____
_____
_____
_____
_____