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NEW PATIENT APPOINTMENT REQUEST

Person completing form: _____Dr. requested: _____

Date:_____ How did you hear about our practice?_____

Patient (legal name): _____

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Parents: _____

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

Home Phone: _____ Work: _____ Cell: _____

Brief Presenting Problem: _____

_____

_____

Legal Custody Information

□ Parents married no custody issues □ Parents divorced joint custody □ Parents divorced mother custody □ Parents divorced father custody □ Other Please Explain _____

Who has physical custody? _____ Who makes medical decisions? _____

Please be advised if parents are divorced, you may be asked to provide a copy of the parenting plan

Primary Insurance

Insurance Co. Name _____ Mental Health Provider Service Phone # _____

Policy Holder's Name _____ Policy Holder's Date of Birth _____

I.D.# _____ Group # _____ Employer: _____

Policy Holder's Address (if different from above): _____

Policy Holder's Relationship to patient: _____

********** **SECTION BELOW FOR OFFICE USE ONLY** **********

Date/By_____Per_____

Effective Date of Coverage _____

APPPOINTMENT:_____

Ind Ded _____ Portion Met _____

Fam Ded _____Portion Met _____

Co Pay _____Co Ins _____

HRA? No Yes_____Balance_____

Out of Pocket Ind _____Met_____

Family _____ Met _____

_____

EDI# or Mailing address _____

_____

_____

Approximate cost_____