Psychiatric Wellness Center

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P: 818-532-7950 F: 818-532-7685

CURRENT MEDICATIONS

PARENT / GUARDIAN INFORMATION (IF MINOR)

Father's Name _____ Phone # _____

Address (if different) _____

Mother's Name _____ Phone # _____

Address (if different) _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____ Phone # _____

OTHER INFORMATION

Primary Care Physician Name: _____ Phone # _____

Have you ever seen a psychiatrist before?
☐ Yes ☐ No, this is my first time.
If Yes, please provide the following information:
Psychiatrist Name: _____ Phone # _____
Reason for seeing a psychiatrist: _____
Are you currently seeing a therapist?
☐ Yes ☐ No
If Yes, please provide the following information:
Therapist Name: _____ Phone # _____
Reason for seeing a therapist: _____

CONSENT

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to PWC. I understand that I am financially responsible for any balance. I also authorize PWC or insurance company to release information required to process my claims.

Patient Signature _____ Date _____
(Parent/Guardian Signature if patient is under 18 years old)

Office Use Only

Name of employee with initial contact with patient: _____ Date _____/_____/_____

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