Psychiatric Wellness Center

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PATIENT INFORMATION

Date _____

First Name _____ Last Name _____ M.I.___

Address _____

City / State / Zip _____

Marital Status S M D W P Sex M F Date of Birth _____/_____/_____ Age _____

Social Security # (Required if insurance is through Medicare or the Military) _____

Primary Phone # _____ Secondary Phone # _____

Email Address _____

Ethnicity _____ Race _____ Household Size _____

How did you hear about the Psychiatric Wellness Center? _____

EMPLOYMENT INFORMATION

Employer _____ Job Title _____

How long have you worked there? _____ Any job-related concerns? _____

REASON FOR VISIT

_____

_____

INSURANCE AND INSURED INFORMATION

Name of Insurance Company _____

Member ID # _____ Group # _____

Policy Holder's Name _____ Relationship to Patient _____

Social Security # of the Subscriber _____ Date of Birth _____

Co-Payment _____ Total Sessions Pre-Authorized _____

PHARMACY INFORMATION

Pharmacy Name _____

Phone # _____ Fax # _____