NORTHWEST BEHAVIORAL MEDICINE

PATIENT IDENTIFICATION

Last Name _____First_____Middle _____

Home Address _____Apt._____

City _____ State _____ Zip _____ Preferred Phone* _____

Date of Birth _____Social Security Number _____ *Ok to leave message? Y or N (circle)

EMPLOYMENT

Employer _____ Address _____

City_____ State_____ Zip _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship_____

Phone Number_____ Address_____

FINANCIAL RESPONSIBILITY

Last Name _____First_____Middle _____

Home Address _____Apt._____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____Date of Birth _____Social Security Number _____

INSURANCE - PLEASE PRESENT YOUR INSURANCE CARD TO OUR RECEPTIONIST

Name of Insurance Company _____

Claims Address _____

Group Number _____Policy Number _____

Effective Date _____ Policy Holder's Name _____ Relationship to Patient _____

Policy Holders Social Security Number _____Policy Holder Date of Birth _____

ADDITIONAL CONTACT INFORMATION

Cell Phone _____ Home Email _____

Work Phone/Email _____ Other _____

IF YOU HAVE INSURANCE THAT REQUIRES PREAUTHORIZATION YOU MUST NOTIFY THE FRONT OFFICE BEFORE EACH VISIT. IT IS YOUR RESPONSIBILITY TO ENSURE THAT YOUR VISITS ARE AUTHORIZED SO THAT THEY MAY BE COVERED BY YOUR INSURANCE.

I hereby authorize any information needed to be released to my insurance company for the sole purpose of authorizing and processing my claims. I understand that I am fully responsible for my bill and will assume any charges not paid by my insurance company. **I understand that I will be charged in full for any appointments not kept unless 24 hours notice is given to the office.** I consent for treatment necessary for the care of the above named patient. I have read, understand, and agree to the office policies attached.

_____ _____

Signature of Patient or Guardian Date

LAST NAME _____**FIRST**_____**MIDDLE**_____

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT:

_____
_____
_____
_____
_____
_____
_____
_____

PLEASE LIST CURRENT DOCTOR(S) AND/OR THERAPIST:

Practice Name & Address: _____

Physician Name: _____Telephone No: _____Fax No: _____

Practice Name & Address: _____

Physician Name: _____Telephone No: _____Fax No: _____

HAVE YOU EVER BEEN HOSPITALIZED IN THE PAST FOR PSYCHIATRIC DIFFICULTIES?
PLEASE LIST ALL HOSPITALIZATIONS & DATES:

Hospital Name: _____ Date(s): _____

Hospital Name: _____ Date(s): _____

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

_____
_____
_____
_____

Pharmacy Name & Phone No:_____

Pharmacy Address:_____

Mail Order Pharmacy Name & Phone No:_____

Mail Order Pharmacy Address: _____

PLEASE LIST ANYONE THAT WE MAY SPEAK WITH REGARDING YOUR CARE (EX: SPOUSE/PARENT ETC.) IF NO NAME IS LISTED WE WILL NOT BE ABLE TO RELEASE INFORMATION TO ANYONE THAT CALLS ON YOUR BEHALF.

_____
_____

Signature: _____ Date: _____
Patient/Guardian