

Thank You for inquiring into our clinic. Each of our clinicians (psychiatrists, psychologist, therapist) are trained, licensed or board certified in their respective profession. Each clinician chooses which insurance panels they accept and which clients they feel they will be able to best serve, considering their present caseload. Please complete this information and return form to; **2015 Maxwell Avenue, Evansville IN 47711**. A mailing label is included. Please send us a copy of your insurance card(s), both front and back. You will be notified by mail to set up an appointment or be referred to a clinic that can best serve you.

How did you learn about our clinic? Please circle all that apply); Phone Book/Friend/Internet/Dr _____

Patient Name: _____ Date of Birth: _____ Patient Age: _____

Patient's SSN# _____ - _____ - _____ (Necessary for insurance/payment/verification purposes, never used for solicitation)

Home Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number(s) where you can be reached. We identify ourselves as "doctor's office" if we must call your work.

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Work # (_____) _____ - _____ Ext : _____

Guarantor/Parent/Legal Guardian/Spouse _____ Phone # (_____) _____ - _____

Primary Care/Family Physician: Dr. _____ Other Doctors? _____

What is the primary reason for this request? _____

_____ (may continue on other side)

Are you requesting a psychiatrist, psychologist, or a therapist? _____

Do you have a history of drug or alcohol abuse? _____

Please include a list of current medications and/or previous psychiatric medications: _____

Please list any mental health care professional you have seen or are currently seeing? Psychiatrist/Psychologist/Therapist/Counselor

Have you ever been hospitalized (Inpatient/IOP) for a psychiatric admission? No/Yes (please list on the other side of this form)

Do any other family members see a doctor or therapist in our clinic? _____

Please include Subscriber Name, Date of Birth, and Social Security Number _____

Are you/Subscriber employed? (List employer) _____ For how long? _____

Are you/Subscriber on sick leave? No/Yes _____ Are the services you are requesting court ordered? _____

Are you/Subscriber on Disability or applying for Disability? No/Yes _____

Do you have a pending Medicaid application? No/Yes _____

How will you pay for treatment? Self Pay (Total amount due at time of service)/Insurance/Other _____

Primary Insurance _____ Identification Number _____

Secondary Insurance _____ Identification Number _____

If you have ever been hospitalized (Inpatient/IOP) for a psychiatric admission, please list all dates and hospitals below:
