New Patient Information Sheet

Name:_____ **DOB**:_____

Phone Number:_____ Can we text appointment reminders? YES NO

Email:_____ Can we email appointment reminders? YES NO

Address:_____

Gender:_____ **SSN**:_____

Current Marital Status:_____

Health Insurance Name:_____

Health Insurance#:_____

What hospital is the member being discharged from? _____

Has the member participated in counseling before? YES NO

When: **Reason**:

List any physical concerns the member is having at present: (e.g., high blood pressure, headaches, dizziness etc.)

What prescription and over the counter medications (and dosage) does the member take at present, and for what purpose?

What is the main reason(s) for establishing care with us?

How long has this problem persisted?