BEHAVIORAL PEDIATRIC & FAMILY THERAPY PROGRAM
NEW PATIENT INTAKE FORM

Name of who referred you to our clinic: ____

Select the specific clinician you were referred to; otherwise, select "General Clinic":

____General Clinic	____George Williams, Ph.D.	____Bryan Miller, Ph.D., LIMHP
____Paulette Cary, Ph.D.	____Rhonda Turner, Ph.D.	____Jami Givens, Ph.D.
____Lucas Bossard, Psy.D.	____Julie Almquist, M.S., LIMHP	____Ann Clare, Ph.D.
____Amanda Setlak, Ph.D.	____Sonya Bhatia, Ph.D.	____Andrew White, Ph.D.

Patient's Primary Care Physician: ____

Patient Legal Name: ________________________________ **Patient Nickname:** ______________

Patient Gender: __________ **Patient Age:** ______ **Patient Date of Birth:** ________________

Biological Mother: ____________________________ **Biological Father:** __________________________

Mother Date of Birth: ___________________ **Father Date of Birth:** ___________________

___ Married ___ Separated ___ Divorced ___ Never Married

Will both biological parents sign a consent for treatment? ___ Yes ___ No

Custodial Parent: ______________________________ **Step-Parent:** ______________________________

Address: ____ **City:** __________________ **Zip:** ____________

Telephone: ______________________ **E-Mail:** ____

<u>Primary</u> Insurance Company: ____

Member ID: ____ **Group No:** __________________________

Policyholder's Name: ____________________________________ **Date of Birth:** ___________________

Deductible: _______/_______ *Copay / Coins:* ________ *(after deductible is met)*

<u>Secondary</u> Insurance Company: ____

Member ID: ____ **Group No:** __________________________

Policyholder's Name: ____________________________________ **Date of Birth:** ___________________

Previous Mental Health Provider(s): ____

Reasons for Prior Therapy: ____

Reasons for Referral to our Clinic: ____

____

Person Completing Form: ____ **Date:** ________________

****

Date: ____________________ | ____________________ | ____________________

Time: ____________________ | ____________________ | ____________________