PATIENT INTAKE FORM

ELLISON & ASSOCIATES OF RALEIGH, P.C
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DATE:_____ ***APPOINTMENT MADE BY:***_____

NAME OF PATIENT (note parent name when minor): _____

Phone #:	Email address:	DOB:
Sex:	Address:	
City:	State:	Zip code:

INSURANCE INFORMATION

Aetna	BCBS	Cigna
Tricare	UHC (UBH/Optum)	Beacon

Mental Health claim submission information on back of card (phone #): _____

Primary Insurance

Policy #/Member ID:	Group #:	Policy holder name:
DOB:	ACA/Employer:	Effective date:

Secondary Insurance

Policy #/Member ID:	Group #:	Policy holder name:
DOB:	ACA/Employer:	Effective date:

REFERRAL SOURCE: _____

TYPE OF PROBLEM (Check all mentioned by patient)

□ ADHD	□ Med. Management	□ Psychosis	□ Grief/Loss
□ Anxiety	□ Bipolar	□ School problems	□ Other:
□ Depression	□ Trauma	□ Work problems	

SCREENING QUESTIONS: We do not specialize or treat patients with the following needs. Do any of the following apply?

Patients who have been identified as sexual offenders (we see children in our office)	Eating disorder	Worker's comp case/injury
Using EAP benefits	Patients with substance use	

NEW PATIENT PARENT APPOINTMENT (for children/adolescents) □ N/A

Date:	Time:	Clinician:

NEW PATIENT APPOINTMENT

Date:	Time:	Clinician: