Women's & Children's Center for Mental Wellness--New Patient Request Form

(Return to (318)-550-3481 or sara@wccmw.com)

Request to see: _____Dr. Saran _____Dr. Singh _____Theresa Stewart, APRN _____Megan Colvin, PA-C ____1st Available

Today's Date: ______________ **Patient Name**: ____

Date of Birth: _________________ Age: _______ Social Security#_________________________________

Address: __________________________________ City: __________________ State: ____ Zip: ________

Home phone: _________________ Cell phone: _________________ Email : ____________________________________

Name of person completing form: _____________________________ Relationship: ____

Referred by: ____

Nature of Problem: ____

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Name of person currently treating this problem? ____

Any Inpatient/ Long-term/Rehab Hospitalization?____

Please list **all current prescribed meds with dosages** or attach a list: ______________________________________

____

Please initial here to attest you have provided a full and accurate account of all prescribed meds _____

Are there concerns about the possibility of injury to Self or Others? ____________________________

If Yes, please go to your nearest emergency room or Psychiatric Hospital for evaluation for need for hospitalization.

Drug(street drugs) Use? __________________________________ **Alcohol Use?** ___________________________

Any current legal charges: ______________________________

Are you currently involved in or seeking Personal Injury lawsuit or child custody case or any legal case that may require psychiatric records, input, or evaluation? ____

On disability? _______, if Yes, for___________________________________ if No, are you seeking disability? ___________________

Type of Insurance: ___Medicare _____Medicaid _____Tricare _____Commercial ____ Self-Pay

Name of Insurance: ____ Phone: _________________________

Primary Insured: _____________________________ SS#: _______________________ DOB: ____________________

Relationship to Patient: ___________________Member # _____________________Group # _________________

****An adult with legal custody most accompany any minor patient to all office visits. Please initial __________ that all questions have been answered honestly. You may be contacted for more information if needed. You will be contacted for appt. setup when a provider has accepted you as a patient and what potentially your insurance benefits will cover for the visit.**