

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

(Return to: by fax (318)550-3481 or by email [contactus@wccmw.com](mailto:contactus@wccmw.com) or turn in "in person")

\_\_\_ Dr. Saran(child/adolescent psych) \_\_\_ Dr. Singh \_\_\_ T. Stewart, APRN \_\_\_ M. 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: \_\_\_\_\_

\_\_\_\_\_

Name of person currently treating this problem? \_\_\_\_\_

Any Inpatient/ Long-term/Rehab Hospitalization? \_\_\_\_\_

Please list **all** current prescribed & OTC 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 \_\_\_ Cash/out of pocket

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. If any of the above is answered falsely, the clinic has a right to abruptly end your appointment/terminate your care.**

**\*\* When/If the appointment is approved and there is a slot available, you will be contacted. We make every effort to do this process within 14 days. But this depends on the availability of the practitioner, thus a guaranteed time for approval/ scheduling cannot be promised. When we make the appointment, we do our best to provide you with info on how much you will owe at the first visit, but this may change (depending on insurance) ; you are responsible for payment asked by the clinic , for your visit, at check-in. Please initial your understanding of this process. \_\_\_\_\_**