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 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 must 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 30 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. _____**