APPROVED or DENIED

PERMIAN PSYCHIATRY
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APPT DATE _____
TIME_____

Date: _____

Acct # _____

REFERRING DOCTOR: _____ NPI: _____

CONTACT NAME/PHONE #: _____ ADDRESS: _____

PLEASE COMPLETE THIS FORM THOROUGHLY. DO NOT LEAVE ANY BLANKS.

After we receive this form we will contact patient to schedule appointment and inform you.

If you have any questions contact Christina Ext 104 or Madu Ext 102

PLEASE FAX BACK TO: (432)333-1335

__ DOCTOR REFERRAL __ LIST OF MEDICATIONS __ COMPLETED FORM __ LAST PROGRESS NOTE ONLY __ COPY OF INS CARD (FRONT & BACK)

Patient Name: _____ M/F Age: _____ D.O.B. _____ SSN: _____

Home #: _____ Cell #: _____ Parent/ Guardian: _____

Address _____ Apt #: _____ City/Zip: _____

Chief Complaint: _____

Has the patient seen a doctor for this condition? **Y \ N** Who & When? _____

Has the patient been hospitalized for psychiatric reasons? **Y \ N** When & Where? _____

Any suicide attempts \ thoughts? Current \ Past **Y \ N** _____

Drug Abuse \ Alcohol Abuse? Current \ Past **Y \ N** _____

Physical \ Emotional \ Sexual Abuse? Current \ Past **Y \ N** Pending Legal Problems \Custody \CPS? **Y \ N** _____

Is the patient violent \ aggressive ? **Y \ N**

Current Medications: _____

Primary Insurance	**Secondary Insurance**
Insurance Company:_____	Insurance Company:_____
Primary Insured: _____	Primary Insured: _____
Relationship to Patient _____	Relationship to Patient _____
DOB: _____ SSN: _____	DOB: _____ SSN: _____
Insurance ID #: _____	Insurance ID #: _____
Group / Account #: _____	Group / Account #: _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
Benefit Phone #: _____	Benefit Phone #: _____

1st VISIT CHARGE: $ _____ NPD$ _____ CASH VISA \ MC \ EDS AUTH # _____