MIDWEST BEHAVIORAL HEALTH
NEW PATIENT REQUEST - ADULT

Person completing this form____ Date_____________

Who referred you to our clinic?____

If you were referred to a specfic clinician, please check their name – otherwise check the service requested

____General Clinic ____Biofeedback/neurofeedback/SSP ____Medication Management

____Kara Antoniak, APRN ____Susan Gripp, APRN ____Julie Maikranz, PhD

____Tim Riley, PhD ____Aaron Stratman, PhD

Patient Primary Care Physician____

Patient Legal Name____

Patient Sex______ Patient Age______ Patient Date of Birth________________

____Married _____Separated _____Divorced _____Never Married

Patient Spouse/Partner____ Date of Birth______________

____Married _____Separated _____Divorced _____Never Married

Patient Address_______________________________________City/State____________________Zip____________

Primary Phone _________________________ Other Phone __________________________

E-mail____

PRIMARY INS _______________________________________ Insurance Phone_____________________________

Member ID_______________________________________ Group ID_______________________________________

Policyholder Name____ DOB______________________

Deductible______________ Copay/Coinsurance_____________

SECOND INS ____ Insurance Phone_____________________________

Member ID_______________________________________ Group ID_______________________________________

Policyholder Name____ DOB______________________

Deductible______________ Copay/Coinsurance_____________

Employer of Insurance Holder____

Previous Mental Health Provider(s)____

Reason(s) for Previous Treatment____

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Reason(s) for seeking treatment at this time?____

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