MIDWEST BEHAVIORAL HEALTH
NEW PATIENT REQUEST - CHILD/ADOLESCENT

Person completing this form_____ Date_____

Who referred you to our clinic?_____

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

____General Clinic ____Biofeedback/neurofeedback ____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_____

Biological Mother_____ Date of Birth_____

____Married _____Separated _____Divorced _____Never Married

Biological Father_____ Date of Birth_____

____Married _____Separated _____Divorced _____Never Married

Will both biological parents sign a consent to treatment form? _____Yes _____No

Custodial Parent_____ Step-Parent_____

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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