mind matters, P.C.
CHILD & FAMILY PSYCHIATRY
www.mindmatterspc.com

New Patient Request Form

****For Psychiatrist and Psychiatric Mental Health Nurse Practitioner requests only. If requesting therapy only, please call our office****

Date _____

Patient Legal Name_____ DOB_____

Patient Preferred name and Pronouns_____ Sex Male_☐ female_☐_ Gender Identity_____

Complete Address_____

_____

Primary Phone_____ Cell☐ Work☐ Home☐ ok to leave detailed msg? yes☐ no☐

2ndary phone _____ Cel☐ Work☐ Home☐ ok to leave detailed msg? yes☐ no☐

Email:_____

Who does patient live with? _____

Names of other family members seen at Mind Matters _____

If applicable

Parent/ Guardian #1_____ Gender ____ DOB _____

Address_____

Phone_____ Cell☐ Work☐ Home☐ Email:_____

Parent/ Guardian #2_____ Gender_____ DOB _____

Address_____

Phone_____ Cell☐ Work☐ Home☐ Email:_____

Financially Responsible Person (Guarantor)- Must be same person who signs patient Financial Responsibility Form. This is who will receive and is responsible for the bill. Mark one:

Self (Must be over 18 to select) ☐ Parent/Guardian #1☐ Parent Guardian # 2☐

Other☐ (list Name, address, phone, DOB and relationship) _____

_____

Name of any current Psychiatrist/Psychologist/Therapist_____

Previous mental health hospitalizations? Yes ☐ No☐ location and length

Pharmacy Name/Address/Phone #_____

Reason for services

_____

_____

_____

Provider Requested (if applicable) _____ Referred by_____

Primary Care Provider (PCP)_____ PCP Phone #_____

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Location requested (Check one): Hillsboro Only ☐ **West Linn Only** ☐ **Either (fastest option)** ☐

Type of Service Requested(circle one): Telehealth ☐ **In Person** ☐ **Either** ☐

Other notes regarding preferences_____

IS THIS A MEDICARE OR MEDICAID POLICY? Yes or No: ____(We do not accept Medicare or Medicaid plans)

Primary Ins_____

Subscriber's Name/ Address_____DOB_____

ID#_____ Group # _____Insurance phone _____

Claims mailing address_____

SUBMIT WITH COPY OF INSURANCE CARD

Mind Matters PC USE ONLY

Deductible:_____CopayCoins:_____OOP Max_____

NOTES: _____

IS THIS A MEDICARE OR MEDICAID POLICY? Yes or No: _____ (We do not accept Medicare or Medicaid plans)

Secondary Ins_____

Subscriber's Name/ Address_____DOB_____

ID#_____ Group # _____Insurance phone _____

Claims mailing address_____

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Mind Matters PC USE ONLY

Deductible:_____

Copay/Coins:_____OOP Max:_____

NOTES: _____