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

Prospective Patient Intake Form Date Completed__________________

Patient Legal Name_______________________________________ DOB______________

Patient Preferred name and Pronouns____

Sex Male____ female____ Gender____________________

Complete Address____

____

Phone___________________________ Cell ☐ Work ☐ Home ☐ Email:_________________________________

If applicable

Parent or Guardian ______________________________________ Gender ____ DOB _____________________

Address____

Phone___________________________ Cell ☐ Work ☐ Home ☐ Email:_________________________________

Parent or Guardian_____________________________________ Gender_____ DOB ___________________

Address____

Phone___________________________ Cell ☐ Work ☐ Home ☐ Email:_________________________________

Name of any current Psychiatrist/Psychologist/Therapist____

Previous mental health hospitalizations? Yes No location and length_________________________________

Reason for services/Special requests

____

____

____

Provider Requested (if applicable) _________________________ Referred by_____________________________

Primary Care Provider (PCP)__________________________________ PCP Phone #_________________________

Location requested (circle one): Either site Hillsboro Only West Linn Only First Available

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

IS THIS A MEDICARE OR MEDICAID POLICY? ________

Primary Ins____

Subscriber's Name___________________________________DOB______________

ID#________________________ Group # _________________Insurance phone _____________________________

Claims mailing address____

SUBMIT WITH COPY OF INSURANCE CARD

Mind Matters PC USE ONLY

Deductible:____

Copay/Coins:________________________________OOP Max:____

NOTES: ____

IS THIS A MEDICARE OR MEDICAID POLICY? ________

Secondary Ins____

Subscriber's Name___________________________________DOB______________

ID#________________________ Group # _________________Insurance phone _____________________________

Claims mailing address____

SUBMIT WITH COPY OF INSURANCE CARD

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Deductible:____

Copay/Coins:________________________________OOP Max:____

NOTES: ____

Hillsboro location:

10690 NE Cornell Rd., STE # 315

Hillsboro, OR 97124

(503) 352-0468

West Linn location:

2020 8th Ave, STE # 230

West Linn, OR 97068

(971) 245-1463