The Oakwood Collaborative
A COUNSELING & ASSESSMENT CENTER

PATIENT INFORMATION

Full Name: _____ SSN: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: _____ Marital Status: _____

Address:_____

City:_____ State:_____ Zip Code:_____

Phone: Home_____ ☐ Work ☐ Cell _____
OK to call and leave vm at this number? ☐Y ☐ N OK to call and leave vm at this number? ☐Y ☐N

Email:_____ OK to email? ☐Y ☐N

Guardian: _____ Phone: _____

Emergency Contact:_____ Phone: _____

Employer: _____
Employment Status: ☐Full-Time ☐ Part-Time ☐None ☐Retired

School:_____ Grade: _____
Student: ☐ Full-Time ☐Part-Time

Referred by:_____

Physician: _____ Current Medications:_____

Reason for visit: ☐ testing/assessment ☐ counseling ☐ other: _____

Preferences about provider at office? (a particular clinician, or more general hopes, such as “male” or “female”, “specializes in working with minority populations”, “speaks Spanish,” etc.) We will do our best to accommodate.

_____

_____

Additional notes on reason for visit:

PAYMENT/INSURANCE SUBSCRIBER INFORMATION

Is patient covered by insurance? ☐Y ☐ N Insurance Plan:_____

Insurance ID #: _____ Group #: _____

Is someone other than the patient responsible for payment and/or providing insurance on the patient? ☐ Y ☐ N

Full Name of Responsible Party/Insured: _____

SSN: _____ Date of Birth:_____/_____/_____ Age: _____ Gender: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone - Home_____ ☐Work ☐Cell _____
OK to call and leave vm at this number? ☐Y ☐ N OK to call and leave vm at this number? ☐Y ☐N

Employer:_____ Relationship to Patient:_____

IF PATIENT IS A MINOR: Please list all names, addresses, and phone numbers of non-custodial parents:

_____

_____

Are there any custody-related legal proceedings in progress or planned? ☐Y ☐ N

I give my permission to (office) to provide psychological services to the patient listed above:

Patient/Legal Guardian Signature:_____ Date:_____