Deaconess Cross Pointe
OUTPATIENT SERVICES

This requested information helps match patients and clinicians by available appointments, education and experience. Please mail completed form along with copies of the front and back of your insurance card to: 445 Cross Pointe Blvd, Suite 320, Evansville, IN 47715. You may also fax to 812-471-4643 and call 812-471-4611 with any questions. This form will be reviewed by our clinical staff and you will be contacted by phone.

DATE: _____

PATIENT NAME: _____ DOB: _____-_____-_____

ADDRESS/ CITY/STATE/ZIP: _____

HOME PHONE: _____-_____-_____ WORK: _____-_____-_____ MOBILE: _____-_____-_____

PLEASE LIST PRIMARY/SECONDARY INSURANCE : _____

NAME OF PREVIOUS PSYCHIATRIST OR FACILITY AND REASON FOR LEAVING: _____

_____

ARE YOU CURRENTLY SEEING ANOTHER MENTAL HEALTH CARE PROFESSIONAL? □ YES □ NO

(IF YES, PLEASE LIST NAME AND FACILITY AND CONTACT THAT PROFESSIONAL TO HAVE YOUR RECORDS FAXED TO US)

_____

PRIMARY CARE PHYSICIAN/NP: _____ OTHER PHYSICIANS/NP: _____

CURRENT MEDICATIONS: _____

_____

_____

_____

HISTORY OF DRUG/ALCOHOL ABUSE? _____

HAVE YOU EVER BEEN DIAGNOSED WITH A MENTAL ILLNESS? IF YES, EXPLAIN? _____

_____

DO ANY OTHER FAMILY MEMBERS SEE A CLINICIAN IN OUR GROUP? _____

ARE YOU REQUESTING A SPECIFIC CLINICIAN (IF AVAILABLE)?_____

ANY OTHER INFORMATION YOU WOULD LIKE FOR US TO KNOW? _____

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