



3500 Government Street
Phone: 318-787-6612 Fax: 318-704-6578
Alexandria, LA 71302

PATIENT INFORMATION

Name: _____ Date: _____

SSN: _____ - _____ - _____ Male _____ Female _____ Age _____ Date of Birth _____

Marital Status: (Please circle) Minor Single Married Separated Divorced Widowed

Address: _____

City: _____ State: _____ Zip _____ Parish _____

Employer: _____

If Child, Parent/Guardian Name: _____

If Child is a Student, Name of School: _____

Race/Ethnicity: _____ Home Phone# _____ Cell Phone# : _____

Language: English Spanish Other: _____

Emergency Contact Name: _____ Contact# _____

Reason for Appt. _____

Who referred you: _____

INSURANCE

Type of Insurance: (Please Circle) Medicaid: Aetna BCB Shield Healthy Blue
AmeriHealth Louisiana Healthcare Connection United Healthcare

Insurance ID Number _____

Current Medication

1. _____ Dosage _____
2. _____ Dosage _____
3. _____ Dosage _____
4. _____ Dosage _____
5. _____ Dosage _____

Current Symptoms, If Yes Please Explain

Anxiety	Yes	No
Depression	Yes	No
Anger/Temper	Yes	No
Drug/Alcohol	Yes	No

If Yes, Please Explain Reason:

Children

How Many Children _____

Name: _____ Age: _____ Sex: _____ Date of Birth: _____

Name: _____ Age: _____ Sex: _____ Date of Birth: _____

Name: _____ Age: _____ Sex: _____ Date of Birth: _____

Name: _____ Age: _____ Sex: _____ Date of Birth: _____

Name: _____ Age: _____ Sex: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____