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

If a question does not apply but the field is required, indicate N/A for "not applicable". Please fill out form **completely .**Asterisk designates required information.

Date* Name of person completing form*

Patient Legal Name* DOB*

Patient Preferred name Pronouns

Sex (required by EMR System)* ☐ Male ☐ Female

Gender Identity (male, female, non-binary, questioning, etc.)

Complete Address*

Primary Contact Phone Number (indicate type of number, include Name if not patient)*

☐ Cell ☐ Home ☐ Work OK to leave detailed msg? ☐ Yes ☐ No

Secondary Contact Phone Number (indicate type of number ,include Name if not patient)*

☐ Cell ☐ Home ☐ Work OK to leave detailed msg ☐ Yes ☐ No

Patient Email Address

Is this a returning patient to Mind Matters?*

Who does patient live with?*

Names of other family members seen at Mind Matters*

If applicable

Parent/ Guardian #1 Gender DOB

Address

Phone

☐ Cell ☐ Home ☐ Work Email

Parent/ Guardian #2 Gender DOB

Address

Phone

☐ Cell ☐ Home ☐ Work 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 ☐ Parent/Guardian #1 ☐ Parent/Guardian #2
☐ Other (if other list name address, phone, DOB and relationship)

Name of any current Psychiatrist/Psychologist/Therapist

Treatment Related

Describe in words why patient is needing to be seen*

Reason patient is needing to be seen (Check all that apply) *

☐ Anxiety ☐ Depression ☐ Ange ☐ Behavioral Problem ☐ Communication Concerns ☐ Mood Swings
☐ Trauma ☐ Disordered Eating (Explain)
☐ Addiction Issues (Explain)

☐ Inattention ☐ Psychosis ☐ Other ☐ Sports ☐ Academic Concerns ☐ Legal (explain)

Has patient been formally diagnosed with a mental/behavioral health condition previously? If so, explain*

Previous mental health hospitalizations? ☐ Yes ☐ No

Location and length of Previous Mental Health Hospitalization

Provider Requested (availability will vary- will be seen faster if patient is matched by Mind Matters with a provider)

Referred By (if applicable)

Primary Care Provider (PCP)*

Primary Care Provider Phone Number*

Pharmacy*

Location requested (check one) * ☐ Hillsboro Only ☐ West Linn Only ☐ Either (Fastest Option)

Appointment Preference* (Please note: One or more appts may be required in person)

☐ In Person ☐ Telehealth ☐ Either (Fastest Option)

Insurance Information (Please note: we do not currently accept Medicare, Med Advantage, or Medicaid plans.) Please submit copy of insurance card(s). If private pay, please indicate

Primary Insurance Name*

Is this a Medicare, Med Advantage, or Medicaid plan? ☐ Yes ☐ No

Subscriber Name*

Subscriber DOB*

Subscriber Relationship to Patient*

Subscriber Address*

ID# * Group Number* Insurance Phone*

Claims mailing address*

BENEFIT INFORMATION (**Mind Matters PC Use Only**)*

Secondary Insurance Name (If applicable)*

Subscriber Name

Subscriber DOB

Subscriber Relationship to Patient

Subscriber Address

ID# Group Number Insurance Phone

Claims mailing address

BENEFIT INFORMATION (**Mind Matters PC Use Only**)*

ADDITIONAL INFORMATION **(Mind Matters PC Use Only)**