Central Texas Mental Health

PATIENT DEMOGRAPHICS

Patient Name		Preferred		DOB
Email				
Birth Gender		Marital Status		
Social Secutrity Number		Driver's License #		State
Cell	Home	Work	Communication Preference	
Street Address (for mailing):			Apartment/Unit #:	
City		State	Zip Code	

INSURANCE INFORMATION

PRIMARY Insurance Carrier:		Member ID #		Group #
Subscriber Name	Relationship		DOB	SSN
SECONDARY Insurance Carrier:		Member ID #		Group #
Subscriber Name	Relationship		DOB	SSN

MEDICARE RECIPIENTS ONLY - Do you have secondary Insurance?

SECONDARY Insurance Carrier:		Member ID #		Group #
Subscriber Name	Relationship		DOB	SSN

Referred by	Primary Care Doctor		Telephone #
Last Physical Exam		What reason?	
Occupation	Employer		Education Level
Race/Ethnicity		Religion	
Sexual Orientation		Gender Identity	

CONTACT IN CASE OF EMERGENCY

Primary Contact Name	Relationship to Patient	Cell #
Secondary Contact Name	Relationship to Patient	Cell #

Treatment Authorization: I authorize Dr. Michael Musgrove and his representatives to provide me with medical care and services**.**

Medical Information: I authorize Dr. Michael Musgrove and his representatives to release any and all information acquired during treatment to other treatment facilities and providers to whom I am under care on an emergent basis, or to persons or entities directly responsible for payment of services (if applicable). I further authorize Dr. Musgrove and his representatives to access electronic prescription history databases for the purpose of my medical care and safety.

Payment agreement: I agree I am financially responsible for the payment fee(s) for service even though insurers may or may not reimburse me.

TREATMENT HISTORY

Why are you seeking help today?

Current Medications | Medication History

Have you ever been hospitalized for mental health reasons?

Facility/Location | Reason | Date

Facility/Location | Reason | Date

Facility/Location | Reason | Date

Have you ever been treated for chemical dependency (ie. detox, rehab)?

Facility/Location | Reason | Date

Facility/Location | Reason | Date

Current Psychiatrist | Since | Last Visit

Have you tried Counseling(ie. talk therapy, CBT)? | Current?

Name of Therapist/Center	Dates	Frequency	Last Visit

MISCELLANEOUS

Place of Residence (if different from mailing address)

Street | Apt/Unit#

City | State | Zip Code

Do you share this residence with anyone else?

Name | Age | Relationship

Name | Age | Relationship

Name | Age | Relationship

Name | Age | Relationship

Name | Age | Relationship

I consent to a photograph (drivers' license style) being taken of me, or to provide one for the exclusive purposes of adding the photo to my digital medical chart. I understand this photo will serve two purposes; 1) as a secondary identifier to avoid office confusion and 2) for providers and staff in recognizing you/prompt familiarity.
I understand that I may decline the photo consent but is not recommended for the above safety reasons. I consent to my photo taken or to be provided to the office:

Patient Name | Signature

Date: