Oliver Winston | BEHAVIORAL URGENT CARE CENTER

PATIENT INFORMATION

Date: _____

Reason for visit: _____

_____

Name: _____ **SS#:** _____ **Sex:**____ **Race:**___

DOB: _____ **Age:** _____ **Marital Status:** _____ **Student Status:**_____

Address: _____ **City, State, Zip:** _____

Home Phone: ( ) _____**Cell Phone: ( )**_____ **Work ( )**_____

Parent/Guardian (if applicable): _____ **Phone Number: ( )**_____

Emergency Contact: _____ **Phone Number: ( )**_____

Referred By: _____

Primary Care Physician: _____

Primary Psychiatrist/Therapist:_____

Pharmacy: _____

Insurance:

Insurance Company: _____ **Insurance ID#:** _____

Customer Service Phone: _____ **Group #:** _____

Insurance Policy Holder Information:

If Same Information as above, Check here: _____

Full Name: _____ **Relationship:** _____

Home Address: _____ **Home Phone Number: ( ):** _____

Occupation: _____ **Employer:** _____

Business Phone Number: ( ) _____ **SS#:**_____ **DOB:**_____

Medication Currently Taken by Client:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Allergies: _____

Physical/MedicalConditions:_____
_____
_____

Has anyone in your family been diagnosed with a mental illness? Y N

If yes, list: (Include diagnosis and relation to you) _____
_____
_____

Briefly describe your sleep habits: _____
_____

Average hours of sleep per night: _____

Do you use tobacco products? Y N Amount: _____ **Frequency:**_____
Do you drink alcohol? Y N Amount: _____ **Frequency:**_____
Do you drink caffeine? Y N Amount: _____ **Frequency:**_____
Do you currently use illegal substances? Y N
Have you used illegal substances in the past? Y N

If yes, what? (Include amount, frequency and date of last use)

_____
_____
_____
_____

I acknowledge the above listed medication and information is complete and correct.

_____ _____
Signature **Date**

_____
Signature of Parent/Guardian