Webster Wellness Professionals
231 W. Lockwood Ave. Ste. 202
St. Louis, MO 63119
TEL (314) 737-4070
FAX (314) 737-4071

PATIENT INFORMATION

Date: ____________ Name: ____ SSN: ____________________ Gender: M or F

DOB and place of birth: ____ Marital Status: S M D W

Cultural Preference: __________________________________ Languages Spoken: _______________________________________

School: ________________________ Employer: __________________________ Military: ______________________________

Medical Leave: Y or N Date: ___________

Referred by: __ McCallum Place __ Insurance Provider Directory __ Internet Search __ Radio/Journal Ad

Friend/Family: ___________________ Professional Referral: ____________________ Other: ________________

Patient Home Address: ________________________________City:_________________________ State: _________ Zip: _______

Home Phone #: ________________________________ Cell Phone #: ____

Work Phone #: ________________________________ Email Address: ____

Parents/Guardian Name(s): ____________________________________ Spouse Name: ___________________________________

Responsible Party name: _______________________________________ DOB: _________________________________

Responsible Party SSN: ____ Relationship: ______________________________

Address: ____City:________________ State_________ Zip_____________

Home Phone #: ____ Cell Phone #: ______________________________

Work Phone #: ____ Employer: _________________________________

Emergency Contact Name: ______________________________ Phone #: _______________________ Relationship:___________

I request that sensitive health information regarding my care at Webster Wellness Professionals be handled in the following way(s):

__You may leave sensitive/confidential medical information on my answering machine or voice mail at the following number(s):

Daytime Phone # _____________________________________ Evening Phone # ____________________________________

__You may send sensitive/confidential medical information to me at the following e-mail address: _____________________________

Do you have Medicare or Medicaid insurance? Y or N Specify: Medicare or Medicaid

If you are a Medicare beneficiary please alert the receptionist immediately. You will need to sign a Medicare Opt Out form.

INSURANCE

1 .**Primary Insurance Company**: ________________ Name of the Insured: ________________

DOB of the Insured: ____________ Mental Health Managed by: ________________

Address for claim submission: ________________

Phone # for precertification/prior authorization: ________________

Policy #: ________________ Group #: ________________

2. **Secondary Insurance Company**: ________________ Name of the Insured: ________________

DOB of the Insured: ____________ Mental Health Managed by: ________________

Address for claim submission: ________________

Phone # for precertification/prior authorization: ________________

Policy #: ________________ Group # ________________

PCP or Pediatrician: ________________ **Therapist Name**: ________________

Address: ________________ Address: ________________

________________ ________________

Phone: ________________ Phone: ________________

Psychiatrist Name: ________________ **Other Provider**: ________________

Address: ________________ Address: ________________

________________ ________________

Phone: ________________ Phone: ________________

Date of Last Physical Exam: ________________ TB Test Date & Results: ________________

Date of Last Dental Exam: ________________ Immunization Records Provided By: ________________

Pharmacy Name: ________________ Phone#: ________________

I hereby consent to all reasonable and ethical treatment deemed necessary and appropriate to address my current physical and psychiatric needs, as determined by Webster Wellness Professionals, on a strictly voluntary basis with the understanding that I may terminate my treatment at will. By signature below, I agree or Guardian agrees to pay and be responsible for any and all billing generated by the Outpatient Practice, less any insurance payments made by in network insurance providers. I understand that payment is due upon invoice for in network insurance carriers or at the time of the service for self pay patients. Co-pays are expected at the time the service is rendered.

________________ ________________

Patient Signature Date

________________ ________________

Guardian Signature Date