Bertrand Wicholas MD
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IDENTIFYING INFORMATION: Today's Date: _____________

Name: ____

LAST NAME FIRST NAME MIDDLE NAME

Birth Date: ________________ Age: ____________ Social Security #:_________________________

Address: ____

Home phone: ________________________________ Work phone: _________________________________

Cell / Pager: _________________________________ Email: _____________________________________

Spouse/Partner/Emergency Contact:

1. Name ____ Phone_______________________________________

Address ____ Relationship _____________________

2. Name ____ Phone_______________________________________

Address ____ Relationship _____________________

Person who referred you to my office: ____

INSURANCE INFORMATION:

Primary Insurance Plan Name (as written on card): ____

Identification #: _________________________________ Group #: ____

Insurance Company's Phone #: ____________________ Insurance Company's Address: _______________________

Subscriber Name: ________________________________ Patient Relationship to Subscriber: ____________________

Subscriber Birthdate: _________________ Subscriber Social Security Number: ________________________________

Subscriber Employer (if applicable): _______________________ Employer's Address: _______________________

Secondary Insurance Plan Name (as written on card): ____

Identification #: _________________________________ Group #: ____

Insurance Company's Phone #: ____________________ Insurance Company's Address: _______________________

Subscriber Name: ________________________________ Patient Relationship to Subscriber: ____________________

Subscriber Birthdate: _________________ Subscriber Social Security Number: ________________________________

Subscriber Employer (if applicable): _______________________ Employer's Address: _______________________

HEALTH INFORMATION:

Your Primary Care Physician: Name ____ Clinic____________________

Phone_____________________ Address _____________________________________ City _____________________

1. Have you been diagnosed or treated for any of the following medical conditions *(please mark if yes)*:

Thyroid problems
Migraine headaches
High Blood Pressure
Asthma
Diabetes
Cancer
Seizures
Closed head injury / loss of consciousness due to trauma
Multiple sclerosis
Stomach ulcers / gastric reflux disease
Irritable bowel
Colitis
Heart disease (including valve disease, conduction abnormality, congestive heart failure, etc.)
Other (Please specify):

2. Do you have any allergies to medications? NO _________ If **YES**, list ___________________________________

3. Current Medications (including prescription drugs, over-the-counter medications, and herbs/vitamins/ minerals, etc.):

Drug Name	Dosage	Drug Name	Dosage

4. Are you currently pregnant? NO _______ If **YES**, please answer following questions:

   # Weeks pregnant: ______ Estimated Due Date: _______________ Number Prior Pregnancies: _____________

   Any Current OB / Medical concerns:

Consent for Treatment, Statement of Financial Responsibility, and Release of Information

I hereby give my consent for psychiatric consultation and treatment. I understand that Dr. Wicholas is an independent practitioner, and no other clinician is involved in this consultation and/or treatment. I agree to be financially responsible for all charges that accrue from consultation and treatment. I agree to be financially responsible for cancelled appointments in accordance with my doctor's cancellation policy. I authorize insurance benefits to be paid directly to the doctor, and that the doctor may release any information to the insurance company required for processing any claims. I have read and received Dr. Wicholas' attached **Office Policies**, understood its contents, and agree to the terms of treatment as stated.

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Name *Signature* *Date*