



HOUSTON OCD PROGRAM

Quality care. Compassionate atmosphere.

Patient Registration Information

(PLEASE PRINT CLEARLY AND COMPLETE ALL PAGES)

PATIENT: (if responsible patient is not the responsible party; fill out information below)

Date of Intake: __

LAST NAME _____ FIRST NAME _____ M. I. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____ WORK _____ CELL _____

PAGER _____ EMAIL _____

AGE _____ DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY NO. _____ - _____ - _____

MARITAL STATUS: (circle) SINGLE MARRIED DIVORCED WIDOWED

STUDENT STATUS: (circle): FULL-TIME PART-TIME NONSTUDENT

Highest Degree Obtained: _____ Year: _____ Institution: _____

EMPLOYMENT STATUS: (circle) : FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

Date last worked: _____ Employer: _____ Position: _____

Emergency Contact: _____ Relationship: _____ Telephone: _____

Financial Guarantor: _____ Relationship: _____ Telephone: _____

PRIMARY INSURANCE COMPANY: _____

PATIENT'S INSURANCE ID#: _____

INSURANCE PLAN NAME: _____ INSURANCE GROUP NUMBER: _____

PREAUTHORIZATION NUMBER (If applicable): _____

RESPONSIBLE PARTY INFORMATION (Only fill out if responsible party different than above):

LAST NAME _____ FIRST NAME _____ M.I. _____

RELATIONSHIP TO PATIENT: Parent; Legal Guardian; Other _____

AGE _____ DATE OF BIRTH _____ SEX _____ SOCIAL SECURITY NO. _____ - _____ - _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE: HOME _____ WORK _____ CELL _____

POLICYHOLDER'S INSURANCE ID#: _____

INSURANCE PLAN NAME: _____ INSURANCE GROUP NUMBER: _____

MARITAL STATUS: (circle): MARRIED SINGLE DIVORCED WIDOWED

STUDENT STATUS: (circle) : FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (circle) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME _____

Have you been in treatment (for mental health issues and/or drug/alcohol) before?

CIRCLE) YES NO (If yes, please complete information below:

Outpatient Therapist: _____ (LPC, LCSW, PHD?) TELEPHONE: _____

How long have you been working with this provider? _____ Frequency of sessions: _____

Outpatient Psychiatrist: _____ TELEPHONE: _____ FAX: _____

How long have you been working with this provider? _____ Frequency of sessions: _____

Have you been in any intensive treatment programs or been hospitalized?

REASON FOR TREATMENT?	WHEN (dates)?	WITH WHOM AND WHERE?	OUTCOME?

MEDICATIONS: (Please list medications you are presently taking):

MEDICATION	DOSAGE	FREQUENCY	PRESCRIBED FOR:

Medical Problems (Please list):

PHYSICAL/MEDICAL CONDITIONS (ANYTHING THAT REQUIRES THE ATTENTION OF A PHYSICIAN): _____

DRUG ALLERGIES: _____

FOOD ALLERGIES: _____

RECENT MEDICAL PROCEDURES OR HOSPITALIZATIONS: _____

PRESENTING PROBLEM: (WHY ARE YOU CURRENTLY SEEKING PSYCHOLOGICAL SERVICES)? _____

TREATMENT GOALS: