

**PATIENT INTAKE FORM**  
 ELLISON & ASSOCIATES OF RALEIGH, P.C  
 2301 Rexwoods Dr, Suite 102, Raleigh, NC 27607 919-787-1932 (PHONE) 919-787-1938 (FAX)

**DATE:** \_\_\_\_\_ **APPOINTMENT MADE BY:** \_\_\_\_\_

**NAME OF PATIENT (note parent name when minor):** \_\_\_\_\_

Phone #:	Email address:	DOB:
Sex:	Address:	
City:	State:	Zip code:

**INSURANCE INFORMATION**

Aetna	BCBS	Cigna
Tricare	UHC (UBH/Optum)	Beacon

**Mental Health claim submission information on back of card (phone #):** \_\_\_\_\_

**Primary Insurance**

Policy #/Member ID:	Group #:	Policy holder name:
DOB:	ACA/Employer:	Effective date:

**Secondary Insurance**

Policy #/Member ID:	Group #:	Policy holder name:
DOB:	ACA/Employer:	Effective date:

**REFERRAL SOURCE:** \_\_\_\_\_

**TYPE OF PROBLEM (Check all mentioned by patient)**

<input type="checkbox"/> ADHD	<input type="checkbox"/> Med. Management	<input type="checkbox"/> Psychosis	<input type="checkbox"/> Grief/Loss
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Bipolar	<input type="checkbox"/> School problems	<input type="checkbox"/> Other:
<input type="checkbox"/> Depression	<input type="checkbox"/> Trauma	<input type="checkbox"/> Work problems	

**SCREENING QUESTIONS: We do not specialize or treat patients with the following needs. Do any of the following apply?**

Patients who have been identified as sexual offenders (we see children in our office)	Patients with eating disorder	Worker's comp case/injury
Using EAP benefits	Patients with substance use	Is this a legal matter?

**NEW PATIENT PARENT APPOINTMENT (for children/adolescents)  N/A**

Date:	Time:	Clinician:
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**NEW PATIENT APPOINTMENT**

Date:	Time:	Clinician:
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