OLA HOU CLINIC PATIENT INFORMATION

Directions: Please fill out the right side of this form as completely as possible, both front and back sides. Please print. Information will be kept confidential. Thank you for your time and attention.

IDENTIFYING INFORMATION	Patient's Full Name:		
	Address:		
	City / State / Zip:		
	Date Of Birth:		
	Social Security #:		
	Marital Status:		
	Ethnic Background:		
	Religion:		
CONTACT INFORMATION Provide all numbers where you might be reached.	Home Phone:		
	Work Phone:		
	Cell Phone / Pager #:		
	E-Mail Address:		
INSURANCE INFORMATION If more than one insurance, please give information for both.	Insurance Company:	1.	2.
	Subscriber #:		
	Plan #:		
	Group #:		
	Date Plan Started:		
IF INSURANCE IS UNDER SOMEONE ELSE'S NAME Skip if insurance is in your name.	Subscriber's Name:		
	Date Of Birth:		
	Social Security #:		
	Employer:		
ACCIDENT / INJURY INSURANCE INFORMATION Fill out if using No Fault or Workers' Compensation insurance.	Insurance Type:		
	Insurance Company:		
	Adjuster's Name:		
	Claim / Case #:		
	File #:		
	Date of Injury:		
REFERRAL INFORMATION Who recommended you to Ola Hou Clinic?	Name:		
	Agency:		
	Address:		
	City / State / Zip:		
	Phone Number:		
	Okay For Us To Send Them A Thank You Note?	☐YES	☐NO

PLEASE CONTINUE THE QUESTIONNAIRE ON THE OTHER SIDE

OLA HOU CLINIC PATIENT INFORMATION CONTINUED

LIST EVERYONE LIVING WITH YOU (THE PATIENT)

Name:	1.	2.
Relationship To You:		
Date Of Birth:		
Name:	3.	4.
Relationship To You:		
Date Of Birth:		
Name:	5.	6.
Relationship To You:		
Date Of Birth:		
Name:	7.	8.
Relationship To You:		
Date Of Birth:		
Name:	9.	10.
Relationship To You:		
Date Of Birth:		

CURRENT EMPLOYMENT OR EDUCATION INFORMATION

If more than one job, or job plus school, then please give information for both.

Company / School:	1.	2.
Address:		
City / State / Zip:		
Position / Major:		
Full Or Part-Time?		
Date Began Job / Study		

PRIMARY CARE PHYSICIAN (PCP) INFORMATION

Name:

Medical Center:

Address:

City / State / Zip:

Phone Number:

PREVIOUS PSYCHOLOGIST OF OTHER MENTAL HEALTH PROFESSIONAL

Name & Title:

Agency:

Address:

City / State / Zip:

Phone Number:

Dates Seen (From / To)

SIGNATURE

I will abide to all the policies in the Ola Hou Clinic Patient Information Handout. Also, if the patient is a minor, I give permission for my child to be treated:

Signed: Date: