NEW PATIENT REFERRAL FORM

Date: _____

Patient Name: _____

If person requesting appointment is not the patient, Name and Relationship: _____

_____

Patient's Age: _____ D.O.B.: _____ SSN: _____

e-mail: _____

Home Phone: _____ Cell: _____ Work: _____

Address: _____

City: _____ State: _____ Zip: _____

Referred by: _____ Phone: _____

PCP: _____ Phone: _____

Reason for referral: _____

_____

_____

_____

_____

Current medications prescribed: _____

_____

Custody/Legal Issues: ☐ YES ☐ NO ; ☐ CURRENT ☐ PAST
History of Psychiatric Hospitalization: ☐ YES ☐ NO
If yes to either of above, please provide details: _____

_____

If patient is a minor:

Mother's Name_____Cell_____Work_____

Father's Name_____Cell_____Work_____

Please check:

☐ **I understand that Dr. Koch is not an in-network provider and does not file insurance claims on behalf of his patients. As such, I agree to be responsible for payment of services provided (regardless of whether or not I am eligible for reimbursement from my insurance provider).**