Walston Health Services

6165 Fuller Court, Suite 2 Alexandria, VA 22310
(703) 924-9810 Fax: (703) 924-7044 walstonhealthservices@gmail.com

Patient Information

First Name: _____ Last: _____ M: _____

Sex: M F DOB: _____ S.S.: _____ Marital Status: ☐S ☐M ☐D ☐W
☐Non-married committed relationship

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____

Preferred Method of communication: Call☐ Text☐ Email☐

Home Address: _____
(Street Address)

_____
(City) (State) (zip)

Insurance

Primary Insurance Company: _____

Identification Number: _____ Group Number: _____

Relationship To Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

If the subscriber is other than patient: Subscriber Name: _____ DOB: _____

Social Security Number: _____ Sex: M F

Secondary Insurance Information

Secondary Insurance Company Name: _____

Identification Number: _____ Group Number: _____

Relationship To Subscriber: Self ☐ Spouse ☐ Child ☐ Other ☐

If the subscriber is other than patient: Subscriber Name: _____ DOB: _____

Social Security Number: _____ Sex: M F

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Guarantor

First Name: _____ Last: _____ M: _____

Sex: M F DOB: _____ Social Security Number: _____

Home Number: _____ Cell Number: _____ Work#: _____

Email Address: _____

Preferred Method of Communication: Call ☐ Text ☐ Email☐

Home Address: _____
(Street Name)

_____
(City) (State) (Zip)

Assignment of Benefits: I authorize my insurance benefits be paid directly to Walston Health Services. I understand that I am financially responsible for any balance. Release of Information: I authorize Walston Health Services, to release any information required to process my claims as allowed by law.

Signature: _____ Date: _____ Print: _____

Emergency Contact

Name of local Friend or relative: _____ Relationship to patient: _____

Contact Address: _____

Phone Number: _____

Allergies: Y☐ N☐ If yes to what? _____

Name of Primary Care Provider: _____ Phone No: _____

Name of Previous Psychiatrist: _____ Phone No: _____

Date of last Physical Exam: _____ Have you ever had an EKG? Y ☐ Date: _____ N ☐

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Name:_____

Current prescriptions and how often you take them:_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems:_____

_____

Past medical hospitalizations/surgeries: _____

Pharmacy Address/Phone No.: _____

I consent to treatment by Dr. Walston, Walston Health Services

Signature: _____Date:_____ Print Name:_____

(December, 2015)