ORION
BEHAVIORAL HEALTH NETWORK

17025 Snowmobile Ln Eagle River, AK 99577

Telephone: (907)-696-7466 Fax: (907)726-0332

Patient Name: _____ Date of Birth: _____ Gender: M/F

Home Phone: _____ Cell Phone: _____

SSN # _____

Address _____

City: _____ State: _____ Zip:_____

EMAIL: _____

Emergency Contact _____

Relationship: _____ Phone: _____

Patients are asked to *check- in at least 15 minutes* prior to an appointment. This allows for collection of insurance information and time for Nurse / Medical Assistant to check-in the patient, a process which may include weight, height measurement, and blood pressure measurement.

Primary Insurance (Type): _____

Subscribers Name: _____ DOB: _____

Subscribers SSN #: _____

ID/Policy Number: _____ Group Number: _____

Secondary Insurance (Type): _____

Subscribers Name: _____ DOB: _____

Subscribers SSN #: _____

ID/Policy Number: _____ Group Number: _____

(Please Provide a copy of the Front and back of card before initial visit)

OBHN is no longer accepting Medicaid for talk therapy. If you have a private insurance with Medicaid secondary, you likely will have a co-pay for therapy services that will be your responsibility

CURRENT EMPLOYER: _____

ADDRESS: _____

PHONE: _____

Chief Complaint

___ MOOD ___ Aggression ___Inattention ___Hyperactivity/Impulsivity ____Anxiety ___ Other

SERVICES PATIENT IS RECEIVING

___ SPEECH Office/Provider _____ Phone Number_____

___ OT/PT Office/Provider_____ Phone Number_____

___ Therapist Office/Provider_____ Phone Number _____

___ ABA Office/ Provider _____ Phone Number _____

___ Other Office/Provider _____ Phone Number _____

Medical History

Primary Care Provider (Office & Doctor): _____ Phone: _____

Current Medications: _____ Dose _____

_____ Dose _____

_____ Dose _____

_____ Dose _____

Any Allergies? (if yes please explain): _____

The Alaska state medical board has issued a directive that the treating physician during a telemedicine encounter request that the patient consent to sending a copy of the records to the patient's primary care provider. OBHN is requesting this of you on their behalf. Any release of your records is voluntary and at your discretion. If you choose to release information to your primary care physician, please provide a Release of Information form.

Who lives in the home with the patient?

NAME	AGE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Trauma History

Has this patient experienced any of the following?

____ YES ____NO ____SUSPECTED Emotional Abuse?

____ YES ____NO ____SUSPECTED Sexual Abuse?

____ YES ____NO ____SUSPECTED Physical Abuse?

____ YES ____NO ____SUSPECTED Neglect?