JulieAnn Krogel, Ph.D. ● Oak Ridge Psychotherapy

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Registration Information: Please complete the following confidential information.

Name (*First, Middle, Last*) _____Social Security # _____
Local Address _____ City _____ State _____ Zip _____
Date of Birth _____ Age _____[ ] Male [ ] Female How long have you lived here? _____
Home Phone #_____ May we call you at home? [ ] Yes [ ] No
Business Phone # _____ May we call you at work? [ ] Yes [ ] No
Cell Phone # _____ May we call your cell phone? [ ] Yes [ ] No
Marital Status [ ] Single [ ] Married [ ] Divorced [ ] Separated [ ] Widowed [ ] Other
If you were married previously give the dates:_____ Email_____
Emergency Contact? Name_____ Phone # _____

Employment Information for [ ] Yourself [ ] Parent [ ] Spouse (check one)
Employer _____ Position _____
Employer Address _____ City _____ State _____ Zip _____

Education/Military/Religion Information
Are you a student? [ ] Yes [ ] No School_____ Grade_____
Highest grade completed in school_____ Major _____ Degree_____
Military Service _____ Dates _____
Religion _____If LDS, Ward/Stake_____ Bishop_____
If LDS, may we provide your bishop with information about your visit? **[ ] Yes [ ] No Initials_____**

Health Information
Current health Problems_____
Current medications _____
Family history of mental health problems_____
_____
Do you use drugs or alcohol? [ ] Yes [ ] No Concerns?_____
Have you received previous counseling? If yes, explain when and
why_____
Have you ever been hospitalized for psychiatric reasons? [ ] Yes [ ] No

Referral Information
Who referred you? _____Phone/Email_____
Who are your Primary Care Provider, Psychiatrist, or other physicians to coordinate care with?
_____
May we provide them with information about your visit? **[ ] Yes [ ] No Initials_____**

Payment Information
Payments to be made by the patient are due at time of service. Payments to be made through insurance, Developmental Services Center (DSC), and the LDS church must be pre-arranged by the patient.
How do you plan to pay? [ ] Cash/Check [ ] Card (2.75% fee) [ ] Insurance [ ] LDS Bishop (Name_____)

Patient's Primary Insurance Information *(please provide copy of card) Mental health coverage [ ] Yes [ ] No*
Name of Insurance Company _____Subscriber's Name_____
Date of Birth _____ Home Phone #_____Work Phone # _____
Address ([ ] Same)_____ City _____ State _____ Zip _____
Patient's relationship to Insured *(check one)*: [ ] Self [ ] Spouse [ ] Child [ ] Other_____
Other Insurance (Name and Address)_____

I understand that regardless of any insurance coverage I may have I am responsible for payment of my account in a timely manner. I hereby authorize payment by my insurance company or other above specified third party directly to Dr. Krogel. I understand that basic information will be released in order to bill for services.

Signature_____ Date _____