

This section for office use only:

Yes No

Appt scheduled with _____ Appointment Date _____ Pt#: _____

Chart

New Patient Intake

Since there are some conditions that the practice does not specialize in, the completion of this questionnaire does not guarantee that we will be able to schedule an appointment for you. This intake will be reviewed by the doctor and a determination will be made as to whether or not an appointment at this office will be beneficial. We will contact you within 2 business days to let you know if we can schedule an appointment.

Caller _____ Date Received _____

Patient's Name _____ Date of Birth _____ Age _____

Address _____

Cell Phone _____ Work Phone _____ Home Phone _____

OK to leave a voicemail? YES NO

Is residence nursing home/other type of assisted living facility? YES NO

Is this evaluation related to any of the following:

- 1.) Eating disorder? YES NO
- 2.) Chemical dependency? YES NO
- 3.) Pending legal discussion/court case? YES* NO
- 4.) Worker's Compensation claim? YES NO
- 5.) Disability claim? YES* NO
- 6.) ADD/ADHD testing? YES NO (when and where?) _____

Primary Ins. _____ ID# _____ Group# _____ ED: _____ Copay: _____
phone number Met Ind: _____

Primary Subscriber: _____ Relation: _____ DOB: _____ Deduct Fam: _____

For All Patients: We ask that you pay your copay (or complete fee for service) at the time of your visit. We will file your insurance for you, but ask that you be familiar with what your policy covers, and what your patient responsibilities are. If unsure of your benefits, call the toll-free number on your insurance card. If you are given a new patient appointment you will need to bring your insurance card to the appointment with you. Do you have any questions regarding this statement? YES NO

For Patients with Out-of-Network Insurance: We will file the claim to insurance for you. If you have out of network benefits, the insurance company should send the payment to you. If they send it to us instead, we will keep the amount as a credit on your account or write you a refund check if you ask for one. Do you have any questions regarding this statement? YES NO

It is not our office policy to obtain prior authorizations for your visits. We ask that the patients obtain any needed prior authorizations or certifications for visits. If your insurance company requires prior authorization, please call the toll-free number on your insurance card to find out what steps you need to take. Do you have any questions regarding this statement? YES NO

Are you aware of any immediate family members that see the Dr? _____

Referring Dr. /Therapist _____ Phone#: _____

Current Psychiatrist _____ Phone#: _____

REASON FOR REFERRAL (Why do you need to see the doctor?):

Is this a second opinion? YES NO

Dates and reason for any prior mental health hospitalizations: _____

Any medical problems? YES NO If yes, please explain _____

Current Medications: (use BACK if needed)

At your first appointment the provider will review your current medications and with regard to any controlled medications, the provider will make the decision about recommended continuation or possible changes.

RX NAME REFERENCE: (Vyvanse) (Adderall) (Concerta or Ritalin (G)- Methylphenidate) (Strattera (G)- Atomoxetine) (Celexa (G)- Citalopram) (Cymbalta (G)- Duloxetine) (Effexor (G)- Venlafaxine) (Fetzima) (Lexapro (G)- Escitalopram) (Neurontin (G)- Gabapentin) (Paxil (G)- Paroxetine) (Pristiq (G)- Desvenlafaxine) (Prozac (G)- Fluoxetine) (Remeron (G)- Mirtazapine) (Trintellix (G)- Vortioxetine) (Vilbyrd (G)- Vilazodone) (Wellbutrin (G)- Bupropion) (Zoloft (G)- Sertraline) (Abilify (G)- Aripiprazole) (Latuda) (Rexulti) (Saphris) (Seroquel (G)- Quetiapine) (Zyprexa (G)- Olanzapine) (Ambien (G)- Zolpidem) (Lunesta (G)- Eszopiclone) (Trazodone) (Ativan (G)- Lorazepam) (Buspar (G)- Buspirone) (Klonopin (G)- Clonazepam) (Vallium (G)- Diazepam) (Vistaril (G)- Hydroxyzine) (Xanax (G)- Alprazolam)