

TEAR HERE

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PATIENT REGISTRATION & HEALTH QUESTIONNAIRE



NAME	MARITAL STATUS S M W D S E P	DATE OF BIRTH	DATE
STREET ADDRESS		CITY	STATE, ZIP
PHONE # - HOME ()	WORK # ()	OCCUPATION/ EMPLOYER	
SPOUSE'S NAME	DATE OF BIRTH	OCCUPATION/ EMPLOYER	PHONE # ()
IF UNDER 18 PARENT / GUARDIAN			
EMERGENCY CONTACT (OTHER THAN SPOUSE)	PHONE # ()	ADDRESS	RELATION
S.S. #	DRIVER'S LICENSE #	REFERRED BY	

INSURANCE & BILLING INFORMATION

BILLING NAME (IF OTHER THAN PATIENT)	RELATIONSHIP
BILLING ADDRESS	PHONE # ()

PAYMENT REQUIRED AT TIME OF SERVICE - UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

1) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	BENEFIT CODE
	GROUP#	I.D.#
2) INSURANCE COMPANY	ADDRESS	EFFECTIVE DATE
NAME OF INSURED	RELATION TO PATIENT	BENEFIT CODE
	GROUP#	I.D.#
MEDICARE I.D.#	MEDICAID I.D.#	
PRESCRIPTION DRUG PLAN		
OTHER COVERAGE		

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to Dr. _____ for services rendered by him / her in person or under his / her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE — MEDICAID

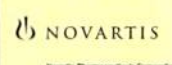
I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

A photocopy of these assignments shall be as valid as the original.

PATIENT NAME (please print)	DATE
PARENT / GUARDIAN (please print)	SIGNATURE

HIPAA COMPLIANT

Make a Difference Today... **Prescribe Zelnorm.**



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New Patient History

Please complete this form and bring it with you to your appointment. If you need additional space please use the back of this paper or feel free to attach another sheet.

Name:

Date:

Brief reason for visit:

Past Psychiatric History:

Psychiatric Hospitalizations: Please list name of hospital, dates of admission and reason for admission

Previous Therapists, Psychiatrists: Please list names, dates and reason for seeing them

Medical History: Check if you have presently or had in the past. Explain on the back

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Irregular Heart Rhythm or rate |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vegetarian diet |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Reflux | <input type="checkbox"/> Irritable Bowel/ diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Sexual dysfunction | <input type="checkbox"/> Menstral Irregularities |
| <input type="checkbox"/> Other | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Loss of Consciousness |
| | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Chronic pain |
| | | <input type="checkbox"/> PMS |

Surgeries: List type of surgery and dates

Drug and Alcohol history:

	Age of 1 st use	Age of last use	frequency of use	amount
Cigarettes				
Alcohol				
Marijuana				
PCP (angel dust)				
LSD (acid)				
Mushroom				
Cocaine				
Ecstasy				
Special K				
Heroin				
Pills:				
IV drugs				
Other				

Have you ever experienced withdrawal? _____ DT's _____ blackouts? _____
 Seizures? _____

Have you ever been in a rehab or detox program? Please list details:

Employment History: Please list your current and previous 2 jobs. List any difficulties.