

TEAR HERE

PAGE #

CHART #

PATIENT REGISTRATION & HEALTH QUESTIONNAIRE



NAME	MARITAL STATUS S M W D SEP	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.**



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

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

Child and Adolescent New Patient History

Name:

Date:

Pregnancy History:

Were there any medical complications during the pregnancy? Y / N . If yes please explain.

Did you take any medications during the pregnancy? Y / N. If yes please list them.

Did you smoke cigarettes during your pregnancy? Y / N , drink alcohol? Y / N
Use drugs Y / N? Please give details if you answered yes.

Was your child born on time? Y / N, Vaginal delivery or C-section?

Was there any complications during the delivery? Y / N , were forceps used? Y / N,
Vacuum suction? Y / N. Please explain if you answered yes

Was there any problems after delivery? (i.e. did your child have jaundice, leave the hospital on time, need any monitors, spend time in the NICU) Y / N. Please explain.

Were there any difficulties during infancy? (i.e. did your child have colic, difficulty being consoled, feeding, sleeping) Please explain

Developmental Milestones:

At what age did your child walk? , say single words? , talk in sentences?

At what age was your child toilet trained? Are there still problems with bed-wetting? Y / N. Please explain if yes.

Were there any specific developmental delays? (i.e. speech, gross or fine motor). If yes please explain.

Were there any difficulties with separation? If yes please explain.

Does your child have any vision or hearing problems? Y / N. If yes please explain.

Relationships:

Describe your child's relationship with peers? (i.e. does child have friends, are they made easily, same age – younger or older, are there any problems, can child work in groups?)