|  |
| --- |
| ***NEW PATIENT REGISTRATION FORM*** |
| **LAST NAME** |  |  |  |  | **FIRST NAME** |  |  |
| **DOB** |  |  |  |  | **SSN** |  |  |  |
| **ADDRESS** |  |  |  |  |  |  |  |  |
| **ADDRESS** |  |  |  |  |  |  |  |  |
| **CITY** |  |  |  | **STATE** |  | **ZIP** |  |  |
| **PHONE (HOME)** |  |  | **PHONE (CELL)** |  |  |  |
| **E-MAIL ADDRESS** |  |  |  |  |  |  |  |
| **MARRIED**  | **DIVORCED**  |  | **SINGLE**  | **WIDOW OTHER**  |
| **HOW DID YOU HEAR ABOUT US** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **EMERGENCY CONTACT INFORMATION** |  |  |  |  |
| **LAST NAME** |  |  |  | **FIRST NAME** |  |  |
| **RELATIONSHIP** |  |  |  |  |  |  |  |
| **PHONE (HOME)** |  |  | **PHONE (CELL)** |  |  |  |
| **PHONE (WORK)** |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **PATIENT INSURANCE INFO** |  |  |  |  |  |
| **NAME OF PRIMARY INSURANCE**  |  |  |  |  |  |  |
| **POLICY#** |  |  |  |  | **GROUP** | **#** |  |  |
| **CO-PAY AMOUNT** |  |  |  |  |  |  |  |
| **INSURANCE COMPANY PHONE NUMBER** |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **SUBSCRIBER SSN** |  |  |  |  |  |  |  |
| **RELATIONSHIP TO PATIENT** |  |  |  |  |  |  |
| **SUBSCRIBER ADDRESS (LEAVE IT BALNK IF IDENTICAL TO ABOBE MENTIONNED ADDRESS)** |
| **ADDRESS** |  |  |  |  |  |  |  |  |
| **CITY** |  |  |  | **STATE** |  | **ZIP** |  |  |
| **PHONE (HOME)** |  |  | **PHONE (CELL)** |  |  |  |
| **PAST MEDICAL HISTORY** |  |  |  |  |  |
| **CURRENT WEIGHT** |  |  |  |  | **HEIGHT** |  |  |
| **ALLERGIES** |  |  |  |  |  |  |  |
| **CURRENT MEDICAL PROBLEMS** |  |  |  |  |  |  |
| **PAST SURGERIES** |  |  |  |  |  |  |  |
| **LIST ALL CURRENT PRESCRIPTION MEDICATIONS/OVER-THE COUNTER MEDICATIONS** |
| 1 |   |   |   | 6 |   |   |   |   |
| 2 |   |   |   | 7 |   |   |   |   |
| 3 |   |   |   | 8 |   |   |   |   |
| 4 |   |   |   | 9 |   |   |   |   |
| 5 |   |   |   | 10 |   |   |   |   |
| **LIST ALL CURRENT SUPPLEMENTS** |  |  |  |  |  |
| 1 |   |   |   | 6 |   |   |   |   |
| 2 |   |   |   | 7 |   |   |   |   |
| 3 |   |   |   | 8 |   |   |   |   |
| 4 |   |   |   | 9 |   |   |   |   |
| 5 |   |   |   | 10 |   |   |   |   |
|  |  |  |  |  |  |  |  |  |
| **PAST PSYCHIATRIC HOSPITALIZATIONS** |  |  |  |  |  |
| **OUPATIENT TREATEMENT** |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
| **INPATIENT TREATEMENT** |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
| **DATE OF YOUR LAST PHYSICAL EXAM** |  |  |  |  |  |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
| **SUBSTANCE ABUSE:** |  |  |  |  |  |  |  |
| **HAVE YOU EVER BEEN TRETAED FOR ALCOHOL OR DRUG USE OR ABUSE?** | **( ) YES** | **( ) NO** |
| **IF YES FOR WHICH SUBSTANCES?** |  |  |  |  |  |
| **IF YES, WHERE WERE YOU TREATED AND WHEN?** |  |  |  |  |
| **HOW MANY DRINKS WOULD YOU HAVE PER WEEK?** |  |  |  |  |
| **HAVE YOU USED STREET DRUGS IN THE PAST 3 MONTHS?** |  |  |  |
| **IF YES, WHICH ONES?** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **HAVE YOU ABUSED PRESCRIPTION MEDICATIONS IN THE PAST 3 MONTHS?** |  |
| **IF YES, WHICH ONES?** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **TOBACCO HISTORY** |  |  |  |  |  |  |  |
| **HAVE YOU EVER SMOKED CIGARETTES?** |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **FAMILY PSYCHIATRIC HISTORY** |  |  |  |  |  |
| **HAS ANYONE IN THE FAMILY BEEN DIAGNOSED WITH OR TREATED FOR:** |  |  |
|  |  | **Mother** |  **Father** |  |  |  | **Mother** | **Father** |
| **BIPOLAR DISORDER** |  |  |  | **SCHIZOPHRENIA** |  |  |
| **DEPRESSION** |  |  |  |  | **PTSD** |  |  |  |
| **ANXIETY** |  |  |  |  | **ALCOHOL ABUSE** |  |  |
| **ANGER** |  |  |  |  | **SUBSTANCE ABUSE** |  |  |
| **SUICIDE** |  |  |  |  | **OTHER** |  |  |  |
|  |  |  |  |  |  |  |  |  |
| IF YES, PLEASE EXPLAIN: |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **TRAUMA HISTORY** |  |  |  |  |  |  |
|  |  |  |  |  |  | **YES** | **NO** |  |
| **WERE YOU ADOPTED** |  |  |  |  |  |  |
| **DID YOUR PARENTS DIVORCE** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **DO YOU HAVE A HISTORY OF ABUSE?** |  |  | **YES** | **NO** |  |
|  |  |  |  | **EMOTIONAL** |  |  |  |
|  |  |  |  | **SEXUAL** |  |  |  |  |
|  |  |  |  | **NEGLECT** |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **IF YOU RESPONDED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN** |  |  |
|  |  |  |  |  |  |  |  |  |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |  |  |
| **IS THERE ANYTHING ELSE THAT YOU WOULD LIKE US TO KNOW** |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
| **SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DATE \_\_\_\_\_\_/\_\_\_\_\_\_/ 2018** |
| **PARENT/GUARDIAN SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **DATE \_\_\_\_\_\_/\_\_\_\_\_\_/ 2018** |
| **EMERGENCY CONTACT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |  |  |  |  |  |