NEW HOPE PSYCHIATRY, LLC.
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Patient Registration Form

The providers and staff at New Hope Psychiatry welcome you to our practice. ***This form along with the Patient Health Questionnaire must be filled out completely****. We look forward to seeing you soon.*

Patient Information

Full Name _____DOB _____

SSN _____Gender _____Race_____

Marital Status _____ Spouse's Name_____

Address _____ City _____

State _____ Zip _____ Mobile Ph _____

Home Ph _____ Work Ph _____

Email address_____

Contact Name if Patient is a Minor _____ Relationship _____

Best Contact: *Circle One*: Cell Phone / Home Phone / Work Phone / Other:_____

Emergency Contact

Emergency contact full name _____

Relationship _____ Mobile Ph _____

Home Ph _____ Work Ph _____

Guardianship: Does the patient have a guardian or caseworker? **Y / N**

Relationship to Patient: _____

Guardian/Caseworker's Name and Phone:_____

Person Financially Responsible

❑ ***If same as patient check here and skip to Insurance Information***

Full Name _____ DOB _____

Relationship to patient _____

Address _____ City _____

State _____ Zip _____ SSN _____

Employer _____ Work Phone _____

Home Phone _____ Cellular Phone _____

Email _____

Insurance Information *********This section must be complete*********

❑ ***If self-pay/no insurance check here***

Primary Insurance Company _____

Phone Number _____

Policy Number _____Group Number _____

Subscriber's Information:

Name _____

Address _____

DOB _____ SSN _____

Relationship to Patient _____

Employer _____Policy Holder's Phone _____

Do you have a co-payment? **Y / N** *****the co-payment or co-insurance is due at the time of the appointment*****

Secondary Insurance Company _____ _____

Phone Number _____ Policy Number _____

Group Number _____ Policy Holder's Name _____

DOB _____ Phone _____ Address _____

Additional Insurance Coverage:

_____

Coordination of Care/Referral Information

Primary Care Provider (PCP)

_____

May we release information to your PCP for coordination of care purposes? **Y / N**

If no, please explain:

_____

If other than your PCP, whom may we thank for referring you to our office?

_____

Patient Health Questionnaire

What is the patient's current symptoms or concerns?

_____
_____
_____

Please list **ALL** of the patient's current daily medications and dosages that are being taken as well as any side effects.

Please list the medications that are currently being taken on this form and bring a written list of medications to the first appointment. You may obtain a list of medications from your pharmacy. On the day of your appointment you MUST BRING A LIST THAT INCLUDES THE NAME OF THE MEDICATION, DOSE, AND HOW THE MEDICATION IS TAKEN.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Which Pharmacy and location do you prefer?

_____
_____

Past Psychiatric History:

Has the patient seen a psychiatric medication provider in the past? **Y / N**

Date Range & Provider Name:

_____
_____
_____

Has the patient seen a therapist, counselor, or psychologist in the past? **Y / N**

Date Range & Provider Name:

_____
_____
_____

Has the patient been hospitalized for psychiatric concerns or gone to treatment in the past?

Y / N

Approximate Date(s) & Reason:

_____
_____
_____

Please list **ALL** previous psychiatric medications taken and their effects.

_____
_____
_____
_____
_____
_____
_____

Is there any history of mental health issues or substance abuse in the patient's immediate family? **Y / N**

If so, who and what? (Please list any medication that you are aware they were/are taking)_____
_____

Medical History:

Who is the patient's Primary Care Provider/Family Physician? When did they last see them?
_____

Can we release information to the PCP for coordination of care purposes? **Y / N**

If no, please explain why:

_____
_____

Are there any allergies to medication, food or environment? **Y / N**

If so to what and the reaction experienced?

_____
_____
_____

Does the patient have any of the following chronic health conditions (***please circle***)?

Asthma / Seizures / Diabetes / High Blood Pressure / Chronic Pain / Thyroid / Cardiac

Headaches / High Cholesterol / Other: _____

Please list any surgeries/hospitalizations:

_____
_____
_____
_____

Has the patient had a sleep study? **Y / N -** If so, what were the results?

_____

Females only: Is the patient pregnant? **Y / N**

If yes, who is the provider? _____ How many pregnancies? _____ How many births? _____

Are they currently taking Birth Control? **Y / N** If so, what type?_____

Social History:

Where was the patient born? _____

Where were they raised? _____

Who was in the patient's family while growing up (who raised patient, parental separations or divorces, how many siblings and ages)?

_____
_____
_____

How long has the patient lived at their current address? _____

Does the patient live alone or with others? If so, who and their relationship to the patient?

_____
_____
_____

Is the patient currently married? **Y / N -** If so, how long? _____
Previous marriages? **Y / N** - If so, how many?_____

Children? **Y / N -** If so, please list sex, name, and age.

_____
_____
_____
_____

Does the patient have any Religious or spiritual preference? **Y / N**
If so, what is it?_____

Is the patient enrolled in school? **Y / N -** If so, where and what grade?

_____
Highest level of education completed?

_____

Does the patient work? **Y / N -** If so, where and what type of work & length of employment?

_____
_____
_____

Health Practices/Habits:

Does the patient drink alcohol? **Y / N**

If so, how often and how much?

_____

Does the patient have previous issues with alcohol causing problems with family/friends/work/school/legal? **Y / N -** If so, when and type of issues?

_____

Drug use? **Y / N -** If so, drug type and frequency?

_____

Does the patient have previous issues with drugs causing problems with family/friends/work/school/legal? **Y / N -** If so, when and type of issues?

_____

Does the patient have concerning or high-risk sexual behaviors? **Y / N -** If so, please explain?

_____

Tobacco use? **Y / N -** What kind and how much used on a daily basis?_____

Previous tobacco use? **Y / N -** What/when did they quit using? _____

Additional Information:

Does the patient have a history of trauma or abuse? **Y** / **N**

If so, please specify (*circle*) as - **child** / **adult** / **or both**

Please specify which type of trauma/abuse (*circle all that apply*) **physical** / **emotional** / **sexual abuse** / **domestic violence** / **Other**

_____
_____

Does the patient have current or past legal issues/charges? **Y** / **N -** If so, please list.

_____
_____
_____

Does the patient have past or current CPS involvement? **Y** / **N -** If so, please indicate when and case worker name.

_____
_____
_____

Does the patient you have a history of disability? **Y** / **N**

For **mental health? Y** / **N -** If so, for how long? _____

For **medical? Y / N -** If so, for how long?_____

Is the patients their own legal guardian? **Y** / **N**

If not please list guardian name and phone number.

_____
_____

What are your and/or the patients treatment goals?

_____
_____
_____
_____

Thank you for your time in completing our paperwork.