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NEW PATIENT INFORMATION

Date: ______________________ DOB: ________________ Referred by: ______________________

First Name: ______________________ Last Name: ______________________

Gender: ☐ M ☐ F ☐ Married ☐ Single ☐ Divorced ☐ Widow Email: ______________________

Address: ______________________

City: ______________________ State: ________________ Zip: ____________

Home Phone: ______________________ Alt Phone: ______________________

Occupation ______________________ Place of Employment ______________________

☐ Self Employed ☐ Unemployed ☐ Homemaker ☐ Student Retired – Prior occupation

☐ Disabled – Disable due to ______________________ ☐ Other ______________________

Briefly explain why you want to be seen today: ______________________

____

ALLERGIES

Please list any Known Allergies: ______________________

____

CURRENT MEDICATIONS

Please list any Medication/Dose/Frequency of Use you are currently taking: ______________________

____

____

____

INSURANCE INFORMATION

Primary Policyholder Information

Insurance Co: ______________________

Group#: ______________________ Policy #: ______________________

Policyholder: ______________________ Policyholder DOB: ______________________

EMERGENCY CONTACT INFORMATION

1st Contact: ______________________ Phone: ________________ Relationship: ________________

☐ I have read and understand the patient privacy information.

Patient Signature: ______________________ Date: ______________________

PAST MEDICAL HISTORY

Last Name: ____ First:_____________________________ DOB: ________________________

TOBACCO / ALCOHOL USE

Tobacco ☐ Nonsmoker *(never smoked)*

☐ Current Use

☐ Cigarettes:________cigarettes/day, __________years smoked ☐ Cigars:_______cigars/day, __________years smoked

☐ Smokeless Tobacco ________________frequency

☐ Past Use

☐ Cigarettes-When did you quit? ______________________ ☐ Cigars-When did you quit? _________________________

☐ Smokeless Tobacco-When did you quit? _______________

Attempts to Quit: ____________ ☐ Never

Alcohol

☐ Never ☐ Non-drinker ☐ Current Alcoholic ☐ in treatment ☐ not in treatment

☐ Past history of alcoholism - Time since last drink__________

☐ Current Drinker Quantity: _______drinks ________ Frequency: ☐ Rare ☐ Social ☐ Regular _____times/week

SUBSTANCE ABUSE HISTORY

Please list any prior or current substance abuse/use and date(s) of use. *Please include prescription and non-prescription substances.*

____

____

MyDrNow

MENTAL HEALTH HISTORY

☐ Unremarkable

☐ Hospitalized for Mental Wellbeing - Complete info below.

☐ Suicide Attempt ☐ ADD ☐ ADHD

☐ Anxiety ☐ Anorexia Nervosa ☐ Bipolar

☐ Bulimia Nervosa ☐ Dementia ☐ Depression

☐ Mental Retardation ☐ Obsessive-Compulsive ☐ PTSD

☐ Post Traumatic Stress Disorder ☐ Schizophrenia ☐ Other (inc. date or age diagnosed)

____

____

Hospitalizations

Reason:____ Date: ______________________

Reason:____ Date: ______________________

A. Past treatment received for any medical/psychiatric problems? ☐ No ☐ Yes

If "Yes" to medical/psychiatric problems describe: ____

B. Under current treatment for any medical/psychiatric problems? ☐ No ☐ Yes

If yes to medical/psychiatric treatment: List Provider Name(s) and Phone number(s):___________________________________

C. Are you currently seeing another provider? ☐ No ☐ Yes

If yes List Provider Name(s) and Phone number(s):____