FAMILY PSYCHIATRY
PRACTICE & ASSOCIATES

CONFIDENTIAL PATIENT INFORMATION INTAKE FORM

Last Name: _____First: _____ MI: _____

Chosen Name: _____ Pronouns: _____

Date of Birth: _____ Age: _____ Gender: _____ SSN: _____

Mailing Address: _____

City/State: _____ Zip: _____

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____

Name of Person(s) Financially Responsible: _____

Relationship to Patient: _____

Address (if different than patient's): _____

City/State: _____ Zip: _____

Employer/School Information:

Name/Location: _____

Occupation:_____Grade:___

Parent/Spouse's Information:

Name: _____ Phone: (____) _____ - _____

Address: _____ City/State: _____ Zip: _____

Emergency Contact Information:

In Case of Emergency, Contact _____Relationship to Patient: _____

Home: (____) _____ - _____ Work: (____) _____ - _____ Cell: (____) _____ - _____ Email: _____

Who can we thank for referring you here today? Google ___ Friend ___ Doctor ___ Other ___

(Referral Name) _____

FAMILY PSYCHIATRY PRACTICE & ASSOCIATES

Medical History

Patient Name: _____ D.O.B: _____

Primary Care Physician

Name of Practice: _____ Doctor: _____

Address: _____ Phone: (___) ____ - _____

Past Psychiatric and Medical Diagnoses

1) _____

2) _____

3) _____

4) _____

Current Medications (Include dosage and frequency)

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

Known Allergies

_____

Severe Illness (childhood to present)

_____

_____

Previous Out/Inpatient Therapy (please specify which)

_____

Stressors affecting you or your family in the past 1-2 years:

__Deaths
__Job Change
__Sexual Abuse
__Births
__School
__Broken Relationship
__Marriage
__Chronic Illness
__Unwanted Pregnancy
__Divorce
__Separation
__Substance Abuse
__Moving
__Physical Abuse
__Medical
__Other

Presenting Problem/Reason for Visit: _____

FAMILY PSYCHIATRY
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PATIENT ACKNOWLEDGEMENT

Patient Name: _____ D.O.B: _____

I understand that the patient's health information is private and confidential. I understand that Family Psychiatry Practice & Associates has policy and procedures in place to assure that patient health information remains confidential and private.

I understand that Family Psychiatry Practice & Associates may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. I understand that sometimes the local state and federal law may require the release of this information without my permission.

Family Psychiatry Practice & Associates has established procedures which help them meet their obligations to patients to keep patient information secure. Their procedures may include other signature requirements from the patient or their representative, written acknowledgements information to be completed, charges for copies and non-routine information needs, etc. I understand that the patient may be required to provide additional consent forms depending on the information requested.

I will assist Family Psychiatry Practice & Associates by following these procedures if I choose to exercise my rights to access the patient's protected health information.

My signature below indicates that I understand the above information and I have addressed any questions I may have regarding patient privacy rights with Family Psychiatry Practice & Associates.

_____

Patient or legally authorized individual signature Date

_____

Printed Name

_____

Relationship to Patient