

## NEW PATIENT INFORMATION

FULL NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ SOC SEC # \_\_\_ - \_\_\_ - \_\_\_ MARITAL STATUS \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_\_) \_\_\_\_\_ WORK : (\_\_\_\_\_) \_\_\_\_\_ CELL: (\_\_\_\_\_) \_\_\_\_\_  
EMAIL: \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
EMERGENCY CONTACT NAME: \_\_\_\_\_ NUMBER(\_\_\_\_\_) \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_

HOW DID YOU HEAR ABOUT RIVER CITY PSYCHIATRY? : \_\_\_\_\_

REASON FOR SEEKING TREATMENT: \_\_\_\_\_

### GUARANTOR/PERSON RESPONSIBLE FOR PAYMENT, IF DIFFERENT FROM ABOVE (FOR PATIENTS UNDER 18, LIST PARENT/GUARDIAN)

NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ PHONE: (\_\_\_\_) \_\_\_\_\_

### PRIMARY INSURANCE COMPANY

NAME OF POLICY HOLDER: \_\_\_\_\_ BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_ PHONE # \_\_\_\_\_  
AUTHORIZATION # \_\_\_\_\_ # VISITS \_\_\_\_\_ START DATE \_\_\_/\_\_\_/\_\_\_ END DATE \_\_\_/\_\_\_/\_\_\_ COPAY \$ \_\_\_\_\_ DED/COIN \_\_\_\_\_

### SECONDARY INSURANCE COMPANY (IF APPLICABLE)

NAME OF POLICY HOLDER: \_\_\_\_\_ BIRTHDATE: \_\_\_/\_\_\_/\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
ID # \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_ PHONE # \_\_\_\_\_  
AUTHORIZATION # \_\_\_\_\_ # VISITS \_\_\_\_\_ START DATE \_\_\_/\_\_\_/\_\_\_ END DATE \_\_\_/\_\_\_/\_\_\_ COPAY \$ \_\_\_\_\_ DED/COIN \_\_\_\_\_

### THERAPIST OR OTHER MENTAL HEALTH PROVIDER

May we contact this person for the purposes of care coordination? YES NO

NAME: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### PRIMARY CARE PHYSICIAN

May we contact this person for the purposes of care coordination? YES NO

NAME: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

### PHARMACY INFORMATION (PLEASE FILL OUT COMPLETELY)

NAME: \_\_\_\_\_ PHONE (\_\_\_\_) \_\_\_\_\_ FAX (\_\_\_\_) \_\_\_\_\_  
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS:** (Please continue on reverse as needed)

**MEDICATION NAME** / **DOSAGE** / **SCHEDULE (e.g AM, PM)** / **REASON FOR TAKING**

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**DRUG/FOOD ALLERGIES:** \_\_\_\_\_

**MEDICAL CONDITIONS (CURRENT/PAST MEDICAL PROBLEMS, SURGERIES, HEAD INJURIES, ETC):** \_\_\_\_\_

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**REASON FOR SEEKING TREATMENT:** \_\_\_\_\_

**PAST TREATMENT HISTORY (please elaborate on any "Yes" responses):**

**HAVE YOU EVER SEEN A PSYCHIATRIST BEFORE? Yes No** \_\_\_\_\_

**HAVE YOU EVER HAD COUNSELING/THERAPY BEFORE? Yes No** \_\_\_\_\_

**HAVE YOU RECEIVED A PSYCHIATRIC DIAGNOSIS? Yes No** \_\_\_\_\_

**HAVE YOU EVER BEEN PSYCHIATRICALY HOSPITALIZED? Yes No** \_\_\_\_\_

**HAVE YOU TAKEN PSYCHIATRIC MEDICATIONS? Yes No** \_\_\_\_\_

**HAVE YOU BEEN DIAGNOSED WITH DEVELOPMENTAL DELAYS? Yes No** \_\_\_\_\_

**HAVE YOU BEEN TREATED FOR ALCOHOLISM/SUBSTANCE DEPENDENCE? Yes No** \_\_\_\_\_

**HAVE YOU ATTEMPTED SUICIDE? Yes No** \_\_\_\_\_

**OTHER SIGNIFICANT PSYCHIATRIC HISTORY:** \_\_\_\_\_

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**IS THERE ANY *FAMILY* HISTORY OF: (PLEASE NOTE RELATIONSHIP TO PATIENT)**

**DEPRESSION: Yes No** \_\_\_\_\_

**BIPOLAR DISORDER OR MANIC-DEPRESSION: Yes No** \_\_\_\_\_

**ANXIETY DISORDER: Yes No** \_\_\_\_\_

**ADHD: Yes No** \_\_\_\_\_

**AUTISM: Yes No** \_\_\_\_\_

**OTHER MENTAL ILLNESS: Yes No** \_\_\_\_\_

**ATTEMPTED/COMPLETED SUICIDE: Yes No** \_\_\_\_\_

**ALCHOLISM/SUBSTANCE ABUSE: Yes No** \_\_\_\_\_

**MEDICAL PROBLEMS (HIGH BLOOD PRESSURE, CANCER, SEIZURES, NEUROLOGICAL CONDITIONS, HEART PROBLEMS, DIABETES, ETC)**

**OTHER SIGNIFICANT FAMILY HISTORY:** \_\_\_\_\_