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NEW PATIENT INFORMATION FORM

Welcome to our office. In order to serve you properly, please provide the following information:

PERSONAL INFORMATION

NAME: (*First, MI, Last*)	SSN (for insurance verification):
TX driver license #:	Date of birth:
Insurance ID Number (BCBS or Aetna): _____ Name of the Insured:_____ DOB of insured:_____	Home Phone number:_____ Mobile:_____ Is it okay to send texts messages: Y or N (circle)
HOME ADDRESS: _____ _____ _____ MAILING ADDRESS (*if different from home)*: _____ _____	Email: _____ Is it okay to email you appointment reminders? (*circle*) Yes or No
EMERGENCY CONTACT: Name:_____ Phone:_____ Relation to you:_____	Valid Credit Card number for charges: _____ Expiration date on credit card: _____ V code: _____

Briefly state why you are seeking treatment and when your problems began:

_____
_____
_____
_____
_____

What psychiatric diagnosis have you been told you have in the past? _____

_____

List Prior psychiatric meds tried: _____

_____

Ever been hospitalized for psychiatric reasons: □ Yes, □ No

Have you ever seen a psychiatrist in the past? □ Yes, □ No
Name and telephone number of most recent psychiatrists:
Dr._____ Phone:_____

MEDICAL AND SURGICAL HISTORY:
Do you have any of the following conditions:

Heart conditions : □ Yes, □ No	Pulmonary disease: □ Yes, □ No
Head injuries: □ Yes, □ No	Seizures: □ Yes, □ No

Disease of eyes: □ Yes, □ No | Kidney disease: □ Yes, □ No
Liver disease: □ Yes, □ No | Joint problems: □ Yes, □ No
Skin conditions: □ Yes, □ No | Gastrointestinal problems: □ Yes, □ No
Urinary problems: □ Yes, □ No | Cancer: □ Yes, □ No
History or heart attacks: □ Yes, □ No | Diabetes: □ Yes, □ No
Other not listed: _____
Are you currently pregnant: □ Yes, □ No
Surgeries you have had: _____

CURRENT MEDICATIONS: List all medications that you are taking (prescribed and not)

_____
_____
_____
_____

Are you allergic to any medication: □ Yes, □ No , which ones: _____

SOCIAL HISTORY:

Where were you born and raised: _____
Where you ever physically, emotionally, or sexually abused: □ Yes, □ No
Marital status: □ single, □ married, □ divorced □ other _____
Who do you live with?_____ Relationship_____
Education level: □ high school, □ college, □ other : _____
Do you smoke tobacco: □**Y,** □ **N** If Yes, how much/day ?_____ Ever been in jail or prison? □ **Y,** □ **N,** If yes, why?
_____ Any current legal problems? _____ Current occupation or prior work history:
_____
If not working, state why or when you retired: _____

USE OF DRUGS:

ALCOHOL: how much: _____
Any history or legal problems due to alcohol? (DWI, PI, etc) □ Yes, □ No
Have you had any problems stopping alcohol? : □ Yes, □ No
Marijuana: □ Yes, □ No, if yes how much/week or month: _____
Tobacco: □ Yes, □ No, if yes, how much/day or week: _____
Opiates: □ Yes, □ No, if yes how much/day:_____ Others (cocaine, amphetamines, etc): □ Yes, □ No

FAMILY HX: List family psychiatric & medical conditions:
Mother: _____
Father: _____
Siblings:_____
Children:

I verify that the above information is truthful to my best knowledge. I agree to have my credit card charge for services not covered by my insurance (if applicable). $25.00 for returned checks. $25.00 for schedule II refills. $35.00 for cancellations made less than 24 hours before appointment. $65.00 for no shows.

_____ _____
Signature date

_____
Printed name