Austin Mind and Behavioral Health

AUSTIN MIND AND BEHAVIORAL HEALTH
NEW PATIENT INFORMATION FORM

PATIENT DEMOGRAPHIC INFORMATION:

Title: ☐ Mr. ☐ Ms. ☐ Mrs.

Last: _____ First: _____ Middle: _____

Suffix: ☐ Jr ☐ Sr ☐ II ☐ III

Date of Birth: ____/____/____ Age: _____ Sex: ☐ Male ☐ Female Ethnicity : _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Spouse's Name: _____

Children (Names and Ages): _____

PARENT OR LEGAL GUARDIAN:

Last: _____ First: _____ Middle: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Last: _____ First: _____ Middle: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

EMERGENCY CONTACT:

Last: _____ First: _____ Middle: _____

Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

FINANCIAL INFORMATION:

Would you be using your insurance or self-pay? _____

Responsible person for payment: _____

Relationship to patient ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____

Date of Birth: ____/____/____ Occupation _____ Employer _____

Address of responsible person _____

Address of Employer _____

Phone numbers of Employer: Office _____ Fax number _____

** Please skip the insurance information, if you are self-pay.*

INSURANCE INFORMATION:

Primary Insurance: _____

Subscriber Name: _____ Date of Birth: ____/____/____

Patient's relationship to subscriber: _____

Name of Insurance: _____

Group No. _____ Policy No _____

** Secondary Insurance (Please fill if you have secondary insurance)*

Subscriber Name: _____ Date of Birth: ____/____/____

Patient's relationship to subscriber: _____

Name of Insurance: _____

Group No. _____ Policy No _____

PAST HISTORY

Have you ever received psychiatric care or therapy? _____

If yes, please provide dates and modalities of treatment- _____

Who is your current psychiatrist? _____

Who is your current therapist? _____

Have you ever been admitted to a psychiatric hospital? _____

If yes, please list the admissions and dates of admission _____

_____

_____

_____

PHYSICAL HEALTH HISTORY

Please check if you have been diagnosed with any of the following:

- ☐ Heart disease
- ☐ Diabetes
- ☐ Liver disease
- ☐ Seizure/Epilepsy
- ☐ STD
- ☐ HIV/AIDS
- ☐ Stroke
- ☐ Cancer
- ☐ High blood pressure
- ☐ Hypothyroidism/Hyperthyroidism

- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Deafness
- ☐ Blindness
- ☐ Migraines
- ☐ Tuberculosis
- ☐ Glaucoma
- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Gout

Have you been diagnosed with any other illness not listed above? _____

If yes, please explain: _____

Allergies: _____

IMMUNIZATIONS:

Have you received all the vaccinations as per CDC recommendations? _____

If no, please explain: _____

_____

SUBSTANCE USE:

Do you currently use or have used in the last 7 days any substances or addictive substances?

If yes, please explain _____

_____

Patient legal name: Please print.

Last: _____ First: _____ Middle: _____

Signature of patient:

Parent/ Legal Guardian legal name: Please print.

Last: _____ First: _____ Middle: _____

Signature of Parent/Legal Guardian

☐ I have read and fully understand Austin Mind and Behavioral Health Office policies and I agree with the policies.