NEW PATIENT REGISTRATION

DATE: _____

ABOUT THE PATIENT

PT. NAME: _____ BIRTH DATE: _____

IF MINOR, PARENT/GUARDIAN NAME: _____

PT. HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PT GENDER: MALE / FEMALE PT. SOCIAL SECURITY NUMBER: _____

RELATIONAL STATUS: _____ REFERRED BY: _____

PT. EMPLOYER: _____

ADDRESS: _____

CELL PHONE: (_____) _____ CALLS ALLOWED: Y / N MESSAGE OK? Y / N

HOME PHONE: (_____) _____ CALLS ALLOWED: Y / N MESSAGE OK? Y / N

WORK PHONE: (_____) _____ CALLS ALLOWED: Y / N MESSAGE OK? Y / N

EMAIL CHECKED REGULARLY _____ EMAIL CONTACT OK? Y / N

EMERGENCY CONTACT: _____RELATIONSHIP:_____
PHONE: (_____) _____

PCP NAME AND PHONE: _____

ABOUT MY INSURANCE COVERAGE

SUBSCRIBER NAME: _____ BIRTH DATE: _____

SUBSCRIBER PHONE (_____) _____SSN: _____

RELATIONSHIP TO PATIENT: SELF PARTNER SPOUSE PARENT OTHER: _____

NAME OF INSURANCE PLAN: _____ EFFECTIVE DATE: _____

ADDRESS TO SEND CLAIMS: _____

SUBSCRIBER ID#: _____ GROUP #: _____

SUBSCRIBER EMPLOYER: _____

ADDRESS: _____

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CITY: _____ STATE: _____ ZIP: _____

WORK PHONE: (_____) _____ CALLS ALLOWED: Y / N MESSAGE OK? Y / N

PHONE NUMBER FOR MENTAL HEALTH AT INSURANCE CO: _____

DOES YOUR INSURANCE COMPANY REQUIRE AN AUTHORIZATION? YES NO

IF YES, WHAT IS THE AUTHORIZATION # _____?

AUTHORIZATION

I verify that the above information is correct and authorize Dr. Benita Chernyk or her designee to file claims with my insurance company. I authorize Dr. Benita Chernyk or her designee to release any medical information necessary to process my claims.

With respect to Medicare and Tricare plans (if relevant), I acknowledge that any information I provided when applying under Title XVIII of the Social Security Act (Medicare) is correct and true to the best of my ability. I authorize Dr. Chernyk to release information to the Social Security Administration or its representatives (including Tricare and managed Medicare plans). I hereby assign to Dr. Chernyk or her designee all payable health care benefits, not to exceed the actual charges. I agree to pay any and all fees that are not covered by my insurance.

I authorize Dr. Chernyk to communicate with my primary physician as named above in writing or by telephone.

I understand that I will be financially responsible for copayments and deductibles at the time the service is rendered. I will give the office a 24-hour notice before canceling appointments or I may be charged for the time I reserved. If an authorization is needed, and I fail to secure one prior to services being rendered, I will be financially responsible for all charges rejected by the insurance company.

I have received the HIPAA Policy Statement and have no further questions about privacy or confidentiality which were not covered in the statement or answered by Dr. Chernyk.

_____ _____

Patient (Parent/Guardian) Signature Date

HEALTH AND WELLNESS HISTORY

NAME	DATE TODAY

EMOTIONAL AND BEHAVIORAL HEALTH

WHY ARE YOU SEEKING HELP TODAY?
WHY DO YOU THINK THIS AN ISSUE RIGHT NOW – WAS THERE SOMETHING THAT TRIGGERED IT?
WHAT MH TREATMENT IN THE PAST [e.g. THERAPY, INPATIENT, IOP, REHAB, PARTIAL HOSP, MEDS, ECT]
WHEN DID YOU LAST SEEK HELP AND ARE YOU CURRENTLY RECEIVING MH TREATMENT? IF YES, WITH WHICH CLINICIAN?
IN YOUR OPINION, WHAT HAS HELPED YOU FEEL BETTER EMOTIONALLY IN THE PAST [e.g. EXERCISE, Rx, MORE SLEEP]

PLEASE CHECK (√) ANY ISSUES TROUBLING YOU TODAY OR IN THE PAST

FAMILY RELATIONSHIPS	CHANGE IN APPETITE
FRIENDS AND COWORKERS	SLEEPING TOO MUCH OR TOO LITTLE
PERFORMANCE AT JOB OR SCHOOL	SEXUAL FUNCTIONING (IF RELEVANT)
LIFE TRANSITION	CONCENTRATION AND MEMORY PROBLEMS
FINANCIAL PROBLEMS	ANGER MANAGEMENT PROBLEMS
MEDICAL PROBLEMS	LEGAL PROBLEMS
ANXIETY OR NERVES	FAITH AND SPIRITUALITY
GETTING HIGH OR DRINKING TOO MUCH	SEXUAL PROBLEMS
ANEMIA	LOW ENERGY
ANXIETY OR PANIC ATTACKS	HIGH BLOOD PRESSURE
BULIMIA OR BINGE-EATING	IRRITABLE BOWEL OR GASTROINTESTINAL PROBLEM
CANCER	EPILEPSY OR OTHER NEUROLOGICAL PROBLEMS
HEART PROBLEMS	OBESITY
DIABETES	DEPRESSION
THYROID PROBLEM	GAMBLING

PLEASE ESTIMATE HOW MUCH OF THE FOLLOWING YOU USE DAILY

ALCOHOL	CIGARETTES
MARIJUANA	LAXATIVES
SLEEPING PILLS	DIURETICS
WATER PILLS	PAINKILLERS
STIMULANTS	CAFFEINE

IS THERE ANYTHING ELSE YOU WOULD LIKE DR. CHERNYK TO ASK YOU ABOUT?