NEW PATIENT APPOINTMENT QUESTIONNAIRE

FORM INSTRUCTIONS

OFFICE USE ONLY
SCHEDULED DATE:_____
PROVIDER:_____

1. If you are an adult patient, you must complete this form yourself in its entirety.
2. We will only schedule an appointment with the patient themselves
3. You will receive a call back from one of our staff members to schedule an appointment within 24 hours.
4. If you have not heard from us, please call 407-423-7149 and speak to an intake coordinator and notify them that you have submitted your form.

TODAYS DATE: _____

REFERRED BY: SELECT

DOCTOR: _____

Do you require handicap accessibility: ☐

OTHER: _____

PATIENT NAME: _____

GENDER: ☐ M ☐ F ☐ Transgender

PATIENT DATE OF BIRTH: _____

CELL: _____

PATIENT SOCIAL SECURITY #: _____

HOME: _____

PAITENT EMAIL: _____

WORK: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

CHIEF COMPLAINTS & PREVIOUS DIAGNOSIS

_____

_____

_____

_____

_____

**IT IS IMPERATIVE THAT YOU ANSWER THE FOLLOWING QUESTIONS AS ACCURATELY AS POSSIBLE.
ANY DEVIATIONS MAY RESULT IN THE PROVIDER NOT BEING ABLE TO FOLLOW-UP WITH YOUR CARE AFTER THE INITIAL CONSULT.**

ALSO, PLEASE KEEP IN MIND THAT IF YOU ARE COMING IN FOR CONTINUATION OF CARE WE CANNOT GUARANTEE THAT OUR PROVIDERS WILL PRESCRIBE THE SAME EXACT MEDICINES THAT YOU HAVE BEEN PRESCRIBED BEFORE.

Please Use The Additional Lines To Further Explain Any Answers

1. TYPE OF PROVIDER YOU WOULD LIKE TO SEE: ☐ Soonest Available ☐ Psychiatrist/ARNP ☐ Counselor ☐ Name of Provider _____

_____

2. HAVE YOU EVER SEEN A PROVIDER IN THIS OFFICE: ☐ Y ☐ N *If yes please list below

_____

3. HAVE YOU SEEN A PSYCHIATRIST/COUNSELOR BEFORE: ☐ Y ☐ N *If yes, please list the last appointment date and reason for discontinuing care below

_____

4. ARE YOU CURRENTLY ON ANY MEDICATIONS: ☐ Y ☐ N *If yes, please list names and dosages below

_____

5. PAST MEDICATIONS (**BRING ALL MEDICATIONS TO APPT.**): *please list below

_____

6. DO YOU HAVE ANY PROBLEMS WITH ALCOHOL OR DRUG ABUSE: ☐ Y ☐ N

_____

_____

7. ANY PROBLEMS WITH ALCOHOL OR DRUG ABUSE IN THE PAST: ☐ Y ☐ N

_____

_____

8. ARE YOU ON DISABILITY OR APPLYING FOR DISABILITY INCLUDING SHORT TERM, LONG TERM, AND OR MEDICAL LEAVE FROM WORK: ☐ Y ☐ N

_____

Please continue to page 2

NEW PATIENT APPOINTMENT QUESTIONNAIRE CONT.

9. HAVE YOU EVER MADE ANY ATTEMPTS TO HURT YOURSELF IN THE PAST OR PRESENT: ☐ Y ☐ N *Please list reason below

_____

_____

10. HAVE YOU EVER BEEN IN THE HOSPITAL FOR THIS COMPLAINT/DIAGNOSIS: ☐ Y ☐ N *Please list most recent hospitalization & total times hospitalized below

_____

_____

At APG we do not double book appointments, therefore we require the information below to reserve your appointment for the initial consultation.

☐ **I understand that the amount of $150 will be charged to my credit card if I do not show up to an appointment or if I fail to cancel within 48 hours (2 business days).**

CREDIT CARD TYPE: -

FULL NAME LISTED ON CARD: _____

CREDIT CARD #: _____

CVV: _____

EXPIRATION DATE: ___ / 20___

FORMS OF PAYMENT ACCEPTED

AMEX . MasterCard . VISA . Discover . Cash

CREDIT CARD CHARGE ACKNOWLEDGEMENT

I, _____, hereby authorize Advanced Psychiatric Group, P.A. for charges pertaining to missed or last minute canceled Initial Appointment (Canceled/missed within 48 business hours of scheduled appointment) and/or professional services rendered.

If I have questions about these charges, I agree to contact Advanced Psychiatric Group, P.A. via e-mail (info@apghealth.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by my provider.

_____

CARD HOLDER SIGNATURE

A photocopy or facsimile of this signature is as valid as the original.

ALL INSURANCE INFORMATION MUST BE COMPLETED

POLICY NAME: _____

PRIMARY POLICY HOLDER: _____

EMPLOYER OF POLICY HOLDER: _____

POLICY HOLDER SOCIAL SECURITY #: _____

POLICY HOLDER DATE OF BIRTH: _____

INSURANCE PHONE NUMBER: _____

MEMBER ID: _____

GROUP #: _____

OPTIONAL - RESEARCH OPTION AVAILABLE

Would you be interested in receiving information regarding our current Clinical Research Studies?

☐ Yes (*We will contact you via telephone*)

FOR OFFICE USE ONLY

EFFECTIVE: _____

CO PAY: $_____

DEDUCTIBLE: $_____

AUTH. REQ: - #: _____

VERIFICATION DATE: _____

OF VISITS: _____

DEDUCTIBLE MET: -

EFFECTIVE DATES: _____ TO _____

PRE-EXISTING WAIVED: -

OF VISITS: _____

SEND CLAIMS TO: _____

REF #: _____

NOTES: _____