NEW PATIENT APPOINTMENT QUESTIONNAIRE

OFFICE USE ONLY
SCHEDULED DATE:_____
PROVIDER:_____

FORM INSTRUCTIONS

1. Legal Guardians, please complete this form in its entirety.
2. If separated or divorced, the GUARDIAN MUST BRING A COPY OF CUSTODY PAPERWORK SO IT CAN BE FILED IN THE PATIENT CHART.
3. Both parents must be present at initial appointment, IF NOT a treatment consent form must be submitted by the non attending parent.
4. We will only schedule an appointment with the patient's legal guardian.
5. You will receive a call back from one of our staff members to schedule an appointment within 24 hours.
6. 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: _____
Does your child require handicap accessability: ☐
REFERRED BY: SELECT
DOCTOR: _____
OTHER: _____

PATIENT NAME: _____
PATIENT DOB: _____
PATIENT SS#: _____
GENDER & AGE: ☐ M ☐ F ☐ Transgnder AGE: -

A. Parent/Legal Guardian Name: _____
Custody Status: -
Cell: _____
Home: _____
Work: _____
Email: _____
Address: _____
City, State, Zip: _____

B. Parent/Legal Guardian Name: _____
Custody Status: -
Cell: _____
Home: _____
Work: _____
Email: _____
Address: _____
City, State, Zip: _____

Parents are divorced: ☐ Y ☐ N
Both parents will attend the initial appointment: ☐ Y ☐ N

Patient (over 12 y/o) COVID-19 Fully Vaccinated: ☐ Yes ☐ No ☐ Under 12
Parent/Guardian A COVID 19 Fully Vaccinated: ☐ Yes ☐ No
Parent/Guardian B COVID 19 Fully Vaccinated: ☐ Yes ☐ No

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 o Further Explain Any Answers

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

_____

2. HAS THE CHILD EVER SEEN A PROVIDER IN THIS OFFICE: ☐ Y ☐ N *If yes please list provider name(s) below

_____

3. HAS THE CHILD SEEN A PSYCHIATRIST/COUNSELOR BEFORE: ☐ Y ☐ N *If yes, please list the last appointment date and reason for discontinuing are below

_____

4. IS THE CHILD CURRENTLY ON ANY MEDICATIONS: ☐ Y ☐ N *If yes, please list below

_____

5. PAST MEDICATIONS (**BRING ALL MEDICATIONS TO APPOINTMENT**): *Please list below

_____

6. DOES THE CHILD HAVE ANY PROBLEMS WITH ALCOHOL DEPENDENCE OR DRUG ABUSE: ☐ Y ☐ N

_____

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

_____

NEW PATIENT APPOINTMENT QUESTIONNAIRE CONT.

8. AS THE GUARDIAN, ARE YOU PLANNING ON APPLYING FOR DISABILITY, INCLUDING LONG TERM, SHORT TERM, OR MEDICAL LEAVE FROM WORK (FMLA):

☐ Y ☐ N **We do not do any disability paperwork in this o e*

9. HAS THE CHILD MADE ANY ATTEMPTS TO HURT THEMSELVES IN THE PAST OR PRESENT: ☐ Y ☐ N *List reason below

10. HAS THE CHILD EVER BEEN IN THE HOSPITAL FOR THIS COMPLAINT/DIAGNOSIS: ☐ Y ☐ N *List most recent hospitalization & otal times hospi alized below

11. WOULD YOU BE INTERESTED IN RECEIVING INFORMATION REGARDING OUR CURRENT CLINICAL RESEARCH STUDIES: ☐ Y ☐ N

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 question about these charges, I agree to contact Advanced Psychiatric Group, P.A. via e-mail (new_patient@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 #: _____

** Reminder to email APG: COVID Card, Ins Card & Photo ID **

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: _____