

# NEW PATIENT APPOINTMENT QUESTIONNAIRE

## FORM INSTRUCTIONS

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.

OFFICE USE ONLY

SCHEDULED DATE: \_\_\_\_\_

PROVIDER: \_\_\_\_\_

TODAYS DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

DOCTOR: \_\_\_\_\_

OTHER: \_\_\_\_\_

Do you require handicap accessibility:

PATIENT NAME: \_\_\_\_\_

GENDER:  M  F  Transgender

PATIENT DATE OF BIRTH: \_\_\_\_\_

CELL: \_\_\_\_\_

PATIENT SOCIAL SECURITY #: \_\_\_\_\_

HOME: \_\_\_\_\_

PAITENT EMAIL: \_\_\_\_\_

WORK: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

COVID-19 Fully Vaccinated: Yes  No

### CHIEF COMPLAINTS & PREVIOUS DIAGNOSIS

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**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

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

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

### FOR OFFICE USE ONLY

EFFECTIVE: \_\_\_\_\_ VERIFICATION DATE: \_\_\_\_\_  
 CO PAY: \$ \_\_\_\_\_ # OF VISITS: \_\_\_\_\_ PRE-EXISTING WAIVED:  
 DEDUCTIBLE: \$ \_\_\_\_\_ DEDUCTIBLE MET:  
 AUTH. REQ: # \_\_\_\_\_ EFFECTIVE DATES: \_\_\_\_\_ TO \_\_\_\_\_ # OF VISITS: \_\_\_\_\_  
 SEND CLAIMS TO: \_\_\_\_\_  
 REF #: \_\_\_\_\_  
 NOTES: \_\_\_\_\_