The Bauman Clinic
a medical corporation

# NEW PATIENT REGISTRATION FORM

## New Patient Registration

Welcome to **THE BAUMAN CLINIC, AMC**. Please fill out the information on this form as accurately as possible so that we may better serve you. **Note: This form will become part of your medical record**

## Personal Information

Today's Date: _____

Patient Name: _____

Mailing Address: _____

City: _____ State/Zip Code: _____

Patient's mobile phone: _____ Work/alternate/parent-guardian phone: _____

Patient SS# (Mandatory) _____Email:_____

Date of Birth: _____ Occupation: _____ Employer: _____

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

Primary Care Doctor: _____ Doctor's Phone: _____

Emergency Contact: _____
Name Relationship Phone #

Who else is living in your home? _____
_____
_____

How did you find out about The Bauman Clinic? ☐ I am a transferring or former patient.
☐ Another doctor ☐ Therapist ☐ Family member ☐ Friend
☐ Newspaper ☐ Website ☐ Other _____

The Bauman Clinic
a medical corporation

# NEW PATIENT REGISTRATION FORM

## Insurance and Billing Information

**Payment in full is required at the time of service, unless other payment arrangements have been made.**

At present, **The Bauman Clinic** is contracted with a very limited number on insurance companies. For most of you, our clinic is considered an "OUT OF NETWORK" provider. Please be aware that you may be entitled to reimbursement from your insurance company even if our clinic is "OUT OF NETWORK". You may be given an invoice at the time of service and you may mail this in immediately to your insurer. You will then be reimbursed by the insurer according to your policy. The amount reimbursed varies, depending on your deductible, type of policy, etc. **PLEASE NOTE**: The Bauman Clinic does not assist with patient reimbursement from insurance companies.

Primary Insurance Company: _____

Name of Insured: _____

Insured Social Security Number: _____

Insured Date of Birth: _____

Employer: _____

Member Number: _____

Group or Policy Number: _____

Patient's Relationship to Insured: ☐ Self- ☐ Spouse ☐ Dependent

Is there a secondary insurance? ☐ Yes ☐ No

**Permission is given to provide/exchange information with my insurance company.**

**I have read the above and agree.** _____

Signature Date

# Medical and Psychiatric History Form

Name: _____Date_____

Date of Birth_____Primary Care_____

Therapist/Counselor_____Therapist's Phone_____

Preferred Pharmacy_____

What are the problem(s) for which you are seeking help?

1_____

2_____

3_____

What are your treatment goals?

_____

_____

_____

**Current Symptoms Checklist:**

| | | |
|---|---|---|
| ☐ Depressive mood | ☐ Racing thoughts | ☐ Excessive Worry |
| ☐ Unable to enjoy activities | ☐ Impulsivity | ☐ Anxiety attacks |
| ☐ Sleep disturbance | ☐ Increase Risky Behavior | ☐ Suicidal thoughts |
| ☐ Loss of Interest | ☐ Excessive energy | ☐ Poor energy |
| ☐ Change in Appetite | ☐ Increased Irritability | ☐ Hallucinations |
| ☐ Concentration/Forgetfulness | ☐ Crying spells | ☐ _____ |
| ☐ _____ | ☐ _____ | ☐ _____ |

***Medical History***

Current medical problems:

_____

_____

Past Medical Problem, nonpsychiatric hospitalizations or surgeries

Allergies_____

Current Weight: _____Height_____

Have you ever had an EKG? ( )Yes ( )No If yes, when_____

Was the EKG ☐ Normal ☐ Abnormal or ☐ Unknown

**List all prescription medications and how often you take them: (If none, write none)**

Medication Name Total Dose Estimated Start Date

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current over the counter medications or supplements:

_____
_____
_____
_____

**Put a check mark:**

| Personal/Family Medical History | You | Family | Which Family Member |
|---|---|---|---|
| Anemia | | | |
| Liver Disease | | | |
| Kidney Disease | | | |
| Heart Problems | | | |

| | | | |
|---|---|---|---|
| High Blood Pressure | | | |
| Asthma/Respiratory Problems | | | |
| Stomach or Intestinal Problems | | | |
| Cancer | | | |
| Fibromyalgia | | | |
| Seizure/Epilepsy | | | |
| Chronic Pain | | | |
| High Cholesterol | | | |
| Head Trauma/Concussion | | | |
| Diabetes | | | |
| Other: | | | |
| | | | |

When your mother was pregnant with you, were there any complications during the pregnancy, birth or developmental in the first few years of life:

_____
_____
_____
_____

**Past Psychiatric History**

| | **Dates** | **Reason** | **Provider/Organization** |
|---|---|---|---|
| Outpatient Treatment | | | |
| Partial Hospitalization Program | | | |
| Rehabilitation/detox | | | |
| Inpatient | | | |
| | | | |
| | | | |

**Past Medication Trials: Put a check mark on the medication you have tried in the past**

| Antidepressants | Antipsychotic |
|---|---|
| Prozac (Fluoxetine) | Seroquel (Quetiapine) |
| Zoloft (sertraline) | Zyprexa (Olanzapine) |
| Luvox (Fluvoxamine) | Geodon (Ziprasidone) |
| Paxil (Paroxetine) | Abilify (Aripiprazole) |
| Celexa (Citalopram) | Clozaril (Clozapine) |
| Lexapro (Escitalopram) | Haldol (Haloperidol) |
| Effexor (Venlafaxine) | Prolixin (Fluphenazine) |
| Cymbalta (Duloxetine) | Risperdal (Risperidone) |
| Wellbutrin (Bupropion) | Latuda (Lurasidone) |
| Remeron (Mirtazapine) | Vraylar (cariprazine) |
| Anafranil (Clomipramine) | Invega (Paliperidone) |
| Pamelor (Nortriptyline) | Other: |
| Elavil (Amitriptyline | |
| Viibrid | |
| Trintellix | |
| Trazodone | |
| Other: | |

| Anti-Anxiety | Mood Stabilizers |
|---|---|
| Xanax (Alprazolam) | Tegretol (carbamazepine) |
| Ativan (Lorazepam) | Lithium |
| Klonopin (Clonazepam) | Depakote (Valproate) |
| Valium (Diazepam) | Lamictal (Lamotrigine) |
| Buspar (Buspirone) | Topamax (Topiramate) |
| Other: | Neurontin (gabapentin) |
| | Trileptal (Oxcarbazepine) |
| | Other: |

| ADHD Medication | Sedative/Hypnotic |
|---|---|
| Adderall (amphetamine salt) | Ambien (Zolpidem) |
| Concerta (Methylphenidate) | Sonata (Zaleplon) |
| Ritalin (Methylphenidate) | Rozerem (Ramelteon) |
| Strattera (Atomoxetine) | Restoril (Temazepam) |
| Vyvanse | Lunesta (Eszopiclone) |
| Guanfacine (Intuniv) | Other: |
| Clonidine (Catapress) | |
| Other: | |

**Substance Use:**

| What | How often | How Much | Last Used |
|---|---|---|---|
| **Alcohol** | | | |
| **Nicotine** | | | |
| **Marijuana** | | | |

| | | | |
|---|---|---|---|
| **Heroine** | | | |
| **Cocaine** | | | |
| **Other:** | | | |

**Family Psychiatric History:**

Has anyone in your family has been diagnosed or treated for:

| Problem | Yes/no | Who | |
|---|---|---|---|
| Bipolar Disorder | | | |
| Schizophrenia | | | |
| Depression | | | |
| PTSD | | | |
| Alcohol use disorder | | | |
| Drugs | | | |
| ADHD | | | |
| Violence | | | |
| Other: | | | |

**I attest that all the information on this form is accurate to the best of my knowledge.**

_____

Patient

_____

Signature of patient, parent or guardian