CHILD/ADOLESCENT
NEW PATIENT PACKET

WAKE
PSYCHIATRY

PATIENT INFORMATION DOCTOR:______________

DATE:____/____/____ SS # ________-_______-_______ DOB:____ /____ /________

NAME:____
(last) (first) (middle)

ADDRESS:____

CITY:______________________________ STATE:____________________ ZIP:____________

PHONE (HOME):________________________ (CELL):_________________________________

EMAIL:____________________________ GENDER: M F Marital Status __________________

APPOINTMENT REMINDER PREFERENCE: ( ) TEXT ( ) EMAIL

EMPLOYER:______________________________OCCUPATION:________________________

SPOUSE/PARTNER NAME: ____

CHILDREN (Name and age)	SIBLINGS (Name and Age)
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

EMERGENCY CONTACT:____

RELATIONSHIP:______________________ PHONE: ________________________________

ADDRESS:____

CITY:______________________________ STATE:____________________ ZIP:____________

PRIMARY CARE DOCTOR:_____________________________ PHONE: __________________

PREFERRED PHARMACY:____

INSURANCE COVERAGE

PATIENT NAME:____

INSURANCE COMPANY____

CUSTOMER SERVICE PHONE#:____

MENTAL HEALTH PHONE# (IF DIFFERENT): ___________________________________

POLICY HOLDER (SUBSCRIBER) NAME:_______________________________________

RELATIONSHIP TO PATIENT: ____

POLICY HOLDER (SUBSCRIBER) ADDRESS:____________________________________

CITY:______________________________ STATE:____________________ ZIP:____________

POLICY HOLDER DOB: _____ / ___ __________ POLICY HOLDER SS#______-_____-______

SUBSCRIBER ID#____________________________ GROUP#_____________________________

Please note that we file with primary insurance only. Our office does not file out-of-network or secondary insurance claims.

Wake Psychiatry, PLLC
Financial Policy

Thank you for choosing Wake Psychiatry for your psychiatric care. We are committed to providing the highest quality of treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your first appointment.

Full payment is due at the time of service. We accept cash, check, Visa or MasterCard.

Our providers are credentialed with several insurance providers. If we are not contracted with your insurance carrier, you are responsible for full payment at the time of service. If you have a deductible, you are responsible for paying each visit in full at the contracted rate for your insurance carrier until you have met your deductible obligation with the carrier. If your insurance carrier requires a co-payment, this is to be paid at each visit. Please notify the office if you have a change in insurance coverage. Authorizations for your first visit are your responsibility.

Our practice is committed to providing the best treatment for our patients and we charge the usual and customary rate for our area. You are responsible for payment for services rendered regardless of any determination made by an insurance company of usual and customary rates or non-charges.

Insurance will not pay for missed appointments. Unless cancelled at least 24 hours (business day) in advance, it is our policy to charge the office rate for the missed appointment. Reminder calls and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment.

Each visit, you will receive a receipt which will show whether there is a balance on your account. Insurance carriers sometimes take a while to collect. The office staff will notify you if there is a balance due that is your responsibility.

Please let us know if you have any questions or concerns.

I have read the policy and agree to the terms.

____ _______________

Signature of Patient or Guardian Date

Notice of Privacy Practices

Our Notice of Privacy Practices may be found on our website at www.wakepsychiatry.com. You may also obtain a copy of this notice from our office staff. By signing below, you acknowledge receipt of this notice. You may refuse to sign this acknowledgement. Please understand that should you refuse to sign, Wake Psychiatry, PLLC will not be able to file to your insurance and you would be fully responsible for all charges.

I,______________________________________, have read or received a copy of this office's Notice of Privacy Practices.

____

Signature

____

Printed Name

____

Date

FAMILY INFORMATION:

PARENT 1

NAME:____ AGE:_____

(last) (first) (middle)

ADDRESS:____

CITY:____________________________ STATE:________________ ZIP:__________

(HOME):_______________(CELL):__________________(WORK)___________________

EMAIL:_____________________________________MARITAL STATUS ____________

EMPLOYER:_____________________________OCCUPATION:___________________

PARENT 2

NAME:____ AGE:_____

(last) (first) (middle)

ADDRESS:____

CITY:____________________________ STATE:________________ ZIP:__________

(HOME):_______________(CELL):__________________(WORK)___________________

EMAIL:_____________________________________MARITAL STATUS ____________

EMPLOYER:_____________________________OCCUPATION:___________________

SOCIAL HISTORY:

This child lives with____

Other children in the family?

Name DOB Name DOB

____

____

____

	YES	NO
Is there any history of abuse (physical / sexual / emotional)?		
Is this child / adolescent sexually active?		
Has this child / adolescent ever had interactions with the juvenille justice system?		
If yes, explain:		
Are there any problems with alcohol, tobacco, illegal substances?		
DSS / CPS?		
If yes, explain:		

EDUCATION:
Grade in School:__________

	YES	NO
1. Has this child/adolescent had to repeat an academic year?		
2. Have there been any disciplinary problems in school?		
If yes, explain ( )suspensions ( )Detentions ( )Expulsion ( )Truancy ( )other		
3. Is there any history of learning disabilities? If yes, explain below		
4. Has the child/adolescent ever received any special education services?		

Explain "other" from question 2: ____

____

Explain "yes" from question 3: ____

____

MEDICAL HISTORY:

1. Does the child/adolescent have any history of:	YES	NO
2. Chest pains or heart problems		
3. Seizures		
4. Operations/Surgeries		
5. Head Injuries / Loss of Consciousness		
6. Frequent Dizziness / Light Headaches / Fainting		
7. Frequent Headaches		
8. Hospitalizations		
9. Other ongoing medical issue(s)		
10. Reaction to drugs or food (allergies)		
11. Non-routine diagnostic tests such as brain MRI, head CT scan, or EKG?		

Explain "ongoing medical issue" from question 9: ________________________________

____

Explain "reactions" from question 10: ____

____

List all medications currently taking:

Medication Dose Date Started Response

____

____

____

____

____

DEVELOPMENTAL HISTORY:

	YES	NO
1. Any problem with pregnancy or delivery of the child/adolescent? If yes, explain		
2. Any problems with development or reaching the following milestones:		
Growth (Height / Weight / Head Circumference)		
Walking / Crawling / Moving / Coordination		
Speech / Talking		
Bowel / Bladder Function		
Social Development / Interaction		
Hearing / Vision		
Onset of Puberty		
Other		

Explain yes response to question 1: ____

____

Explain "other" from question 2: ____

____

FAMILY HISTORY:

Is there any family history of:	YES	NO
1. Bipolar Disorder		
2. Depression		
3. Anxiety		
4. Schizophrenia		
5. ADD / ADHD		
6. Seizures		
7. Chest Pains, Heart Problems, or Sudden Cardiac Death		
8. Alcohol or Drug Problems		
9. Mental Retardation or Autism		
10. Other		

Explain "other" from question 10: ____

____

HABITS:

Are there any problems with:	YES	NO
Sleep		
Appetite / Eating / Nutrition		

List any Hobbies / Interests: ____

____

SOCIAL INTERACTIONS:

This child / adolescent:	YES	NO
Gets along with others the same age		
Gets along with adults		
Easily makes friends		
Is able to keep friends		
Has appropriate social skills		
Has problems with peer pressure		
Has problems with aggression (i.e., fights / threats / etc.)		
Is destructive of property		
Steals		
Lies		
Often loses temper / has tantrums		
Often argues with adults		
Actively defies / refuses to comply with rules		
Does things to deliberately annoy others		
Blames others		
Often touchy or easily annoyed		
Often angry or resentful		
Often spiteful or vindictive		
Is bullied or bullying		
Has difficulties with sexual identity / orientation issues		

ATTENTION:

This child / adolescent often:	YES	NO
Fails to give close attention to details or makes careless mistakes		
Has difficulty sustaining attention		
Does not seem to listen when spoken to directly		
Does not finish tasks		
Has trouble organizing		
Avoids tasks that require sustained mental effort		
Loses things		
Forgets things		
Is easily distracted		

HYPERACTIVITY / IMPULSIVITY:

This child / adolescent often:	YES	NO
Fidgets or squirms		
Has trouble sitting still		
Runs or climbs excessively		
Has difficulty doing things quietly		
Has excessive energy		
Talks excessively		
Blurts out answers		
Has difficulty waiting		
Interrupts or intrudes		

MOOD / ANXIETY:

This child / adolescent often:	YES	NO
Has mood swings		
Is unhappy / sad		
Has low self-esteem		
Has no energy / motivation		
Does not like change / wants things just right		
Easily frustrated or overwhelmed		
Nervous / Worrying / Fearful		
Does things over and over		
Has unpleasant thoughts that he /she can't get rid of		
Feels his / her mind is always active and unable to relax		
Has bizarre or odd behaviors		

PSYCHIATRIC HISTORY:

Individual or Family Therapy

Mental Health Provider　　Dates　　Response

____

____

____

Psychiatric Hospitalization

Location　　Dates　　Reason Hospitalized

____

____

____

Past Psychiatric Medications

Medication　　Dose　　Dates Used　　Response /Side Effect

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