FLINT HILLS
neuropsychology

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New Patient Information

Name: _____ Date of Birth: _____

Street: _____ City: _____ State: _____ Zip: _____

Phone: _____ (Circle: Home Work Cell Other contact: _____)

Phone: _____ (Circle: Home Work Cell Other contact: _____)

Phone: _____ (Circle: Home Work Cell Other contact: _____)

Email address: _____

Employer (or if a student, list school, year/grade, and degree program):

_____

May we call you at these numbers? (Y/N): Home_____ Work _____ Cell _____ Other _____

May we leave a voicemail? (Y/N): Home_____ Work _____ Cell _____ Other _____

What is your preferred method for appointment reminders? (circle) Email Text Phone call

Occupational Status:

_____Full-time student

_____Part-time student

_____Homemaker

_____Retired

_____Disability

_____Unemployed

_____Part-time employed

_____Full-time employed

Occupation/Job title:

_____

Education:

_____Years Completed

_____Highest Degree

Handedness (circle):

Right/Left/Ambidextrous

Marital Status:

_____Single

_____Live-in/partnered

_____Married

_____Separated

_____Divorced

_____Widowed

Ethnicity:

_____

Briefly describe the symptoms you are having and when they began:

_____

_____

Are these symptoms the result of an injury? Yes____ No____ If so, date of injury: ____/____/_____

Was it a motor vehicle accident? Yes____ No____ Were you injured at work? Yes____ No____

Are you represented by an attorney? Yes____ No____ If so, name of attorney:_____

Health History

Please list your current treating physicians:

PHYSICIAN SPECIALTY

_____

_____

_____

Please list the names and dosage of any prescription or non-prescription medication you are currently taking including vitamins, herbals, or supplements (or, you may bring a separate list):

MEDICATION DOSAGE

_____

_____

_____

_____

_____

_____

_____

_____

Indicate any chronic medical conditions or prior surgeries/hospitalizations:

_____

_____

_____

List any prior mental health or substance abuse problems or treatment history:

_____

_____

List any head injuries or concussions with dates:

_____

_____

Emergency Contact: Please list an adult we may call in case of an emergency.

Name: _____ Address:_____

Relationship to you: _____ Phone Number: _____

Do you have a legal guardian, conservator, or power of attorney? _____

Name: _____ Address:_____

Relationship to you: _____ Phone Number: _____

Primary Health Insurance

Insurance Company: _____ Phone Number: _____

Claims Address: _____

Insurance I.D. Number: _____ Group/Policy Number: _____

Policy holder's name as it appears on the card: _____

Policy holder's birthdate: ____/____/_____

Patient's relationship to policy holder: _____

Secondary Health Insurance

Insurance Company: _____ Phone Number: _____

Claims Address: _____

Insurance I.D. Number: _____ Group/Policy Number: _____

Policy holder's name as it appears on the card: _____

Policy holder's birthdate: ____/____/_____

Patient's relationship to policy holder: _____

For those not using insurance:

Will you be paying for the fees yourself or will they be paid by another responsible party?

Self-pay: _____

Other (name and contact information): _____

_____

Informed Consent & HIPAA Acknowledgment

Please **initial** each statement and sign at the bottom of the page.

1. ____ I grant permission to release any required information and reports to my insurance company in order to process my claims for services. Additionally, I authorize payment of medical benefits to the supplier of services. I also understand that I am responsible for any fees not covered by my insurance company. (required only if you will be using insurance benefits for payment)

2. ____ I have reviewed the Informed Consent & HIPPA document offered to me and/or that is available online (http://www.flinthillsneuropsych.com) and I understand my rights and responsibilities.

3. ____ I understand that there is a $250 fee billed directly to me for testing sessions that are missed or canceled with less than 72 hours notice, and a $45 fee billed directly to me for any other sessions that are missed or canceled with less than 24 hours notice (such as psychotherapy or feedback sessions).

Signed_____ Date_____

Patient's Name (Please Print): _____