Frances Baumgarten, Ph.D.
3419 Via Lido #353
Newport Beach, CA. 92663
949-474-8442

NEW PATIENT INFORMATION

Today's Date _____

Patient's Name _____

Date of Birth _____ Age_____

Address _____
Street City State Zip Code

Telephone _____ _____
Home Cell

School _____Grade_____

Primary Care Physician_____Telephone_____

Referred By _____

Parents or Guardian or Close Relative To Be Contacted In Case Of Emergency.

Please give 2 contacts if possible.

Name _____Relationship_____

Telephone _____

Name _____Relationship_____

Telephone_____

Medical History:

PATIENT SIGNATURE_____

Prescription Drugs /Over The Counter Medications:

_____

Medical Conditions Present and Past:

_____

Psychiatric History:

Therapy Dates and Professional's Name:

_____

Medications Prescribed and Psychiatrist's Name:

_____

Family History:

Describe Medical or Psychiatric Conditions of any Relatives:

_____

Habits:	Amounts Currently Using	Most Ever Used
Coffee (cups/day)		
Cigarettes (Packs/day)		
Alcohol		
Vaping		

Substance Abuse History: **Yes. No**

If Yes please describe:

Substances	Amounts	Frequency	When (First use/Last use)

_____

Do you have a history of Blackouts? Yes No

Please Check all Symptoms and Concerns.

Depressed Mood	Hyperactivity	Sleeping Patterns
Decreased Energy	Disruption of Thoughts	Eating Patterns
Hopelessness	Delusions	Sexual Orientation Concerns
Guilt	Hallucinations	Difficulty Paying Attention
Anxiety	Paranoia	Difficulty Concentrating
Panic Attacks	Periods of Dissociation	Impulse Control
Phobias	Memory Loss/ Recall Difficulty	Self Harm/ Cutting
Irritability	Physical Abuse	Anger Management
Worthlessness	Sexual Abuse	Suicidal Thoughts or Attempts
Grief	Assaults	Thoughts of Harming Others
Worry/Fears	Physical Complaints	Other_____

Recent Changes in Lifestyle. Circle all that apply.

Family Living Arrangement Health Friendships. School Activities Legal.

PATIENT SIGNATURE_____

Frances Baumgarten, Ph.D
1000 Quail Street #187
Newport Beach, CA 92660
949-474-8442

CONSENT TO RELEASE AND RECEIVE INFORMATION:

This consent is for Dr. Baumgarten to contact by telephone, or/and to send copies of these records to one or all of the following health care providers:

Primary Care Physician Psychiatrist Oncologist Nurse Practitioner/Navigator

Name: _____

Phone: _____Fax:_____

Address: _____

.

For developing, implementing and providing a comprehensive treatment plan.

Patient's Name: _____ Date: _____
(Please Print)

Patient's Signature: _____ Date:_____

Guardian or Parent's
Signature if patient is under 18. _____ Date: _____

This consent is valid for as long as the patient is in treatment with Dr. Baumgarten, unless written notification is provided to Dr. Baumgarten.

( ) I do not give my permission to release any information to any health care providers.

CONSENT TO CONTACT

PATIENT SIGNATURE_____

I GIVE PERMISSION FOR DR. BAUMGARTEN TO CONTACT ME IN THE FOLLOWING MANNER.

By Telephone: Please circle Yes or No

Home_____Consent to leave a message. Yes No

Cell_____ Consent to leave a voice message Yes No

Consent to leave a text message Yes No

Email: _____

Consent to Receive: Invoices, Appointments, Telehealth Invites, Confidential Notifications. Yes No

Mail: Address for Parent where I can send information i.e.: bills, statements and letters.

Please feel free to contact me in writing if you wish to change these consents. I cannot guarantee that a message on my phone will be received accurately. Therefore, phone messages will not be sufficient consent to change this permission form.

Patient Signature_____

Date _____

PATIENT SIGNATURE_____