Patient Intake

Date _____

Requested Provider *Dr Almhana* Intake Coordinator *Other* Form Completed By Office Staff

This is a direct referral.

Patient Name _____ Gender *Male*

DOB _____ Last Four Digits of Social Security Number _____

Street Address _____ City _____ Zip _____

Phone _____ *Cell* OK to Leave Message? *Yes*

Phone _____ *Cell* OK to Leave Message? *Yes*

Patient is a Minor *No*

Guardian Name _____ Relationship to Patient *Parent*

Referral _____

Brief History (The reason you would like to be seen.) *None*

Have you received psychiatric treatment in the past? *Yes*

If so, from whom? _____ How long ago? _____

Who is your primary care physician? _____

Are you currently being treated for any medical conditions you feel the Doctor should be aware of (i.e. hypertension, heart condition or thyroid condition)? *No* *None*

Are you currently taking any medications, including anything over the counter? *No*

Do you have any drug allergies? *No*

The following basic set of questions is asked to every patient regardless of their reason for requesting treatment.

Drug Use *No* Date of Last Use _____

Drug(s) Used _____

Alcohol Use *No* Frequency _____

Do you currently have any thoughts or plans to commit suicide & how long ago? *No*

Do you currently have any thoughts or plans to harm yourself or others & how long ago? *No*

If at anytime you feel your symptoms become worse or unmanageable prior to your initial evaluation with the physician in this office, please do not wait for your appointment, proceed to the nearest emergency room for evaluation. We recommend Mercy Hospital, Fairview Hospital, or Southwest General Hospital. You can also contact the Nord Emergency Stabilization Services at 800.888.6161.

Do you currently have any legal issues (i.e. bankruptcy, divorce, domestic violence)? *No*

Are you currently working? *No* Are you currently receiving disability? *No*

Covering Physician _____

Reason for Disability _____

Start Date of Disability _____ Estimated Return to Work Date _____

Please be advised that the Doctors DO NOTcover any disability paperwork until the patient has been seen for at least six months in this office.

~~Primary~~ Insurance Other

Network *In-Network* Phone Number _____

Identification Number _____ Group Number _____

Policy Holder _____ Gender *Male*

DOB _____ Last Four Digits of Social Security Number _____

Relationship to Patient *Other*

Insurance Representative _____

Effective Date _____ Co-Pay _____

Deductible _____ Co-Insurance _____

Out-of-Pocket Max _____ Co-Insurance _____

Visit Limit _____ Pre-Certification *No*

Secondary Insurance

Network *In-Network* Phone Number _____

Identification Number _____ Group Number _____

Policy Holder _____ Gender *Male*

DOB _____ Last Four Digits of Social Security Number _____

Relationship to Patient *Other*

Insurance Representative _____

Effective Date _____ Co-Pay _____

Deductible _____ Co-Insurance _____

Out-of-Pocket Max _____ Co-Insurance _____

Visit Limit _____ Pre-Certification *No*

Someone will contact you within the day to schedule your initial assessment with the physician, unless it's a Thursday as the office is closed on Friday. Once your evaluation is scheduled you must give at least twenty-four hour notice to cancel or reschedule your appointment.

FOR OFFICE USE ONLY

Date Sent to Provider

Provider Response Dr. Haidar Accepted

Contacted	*No*		Left Message	*No*	
Scheduled	*No*		Not Interested	*No*	