**Attending physician (office use only):** **Account # (office use only):**

# Norfolk Psychiatric Associates – New Patient Application

Welcome to our office! Please complete the requested information, provided below, to the best of your ability so we may work to establish the most appropriate services for your case. If more appropriate providers for the treatment of your needs are located elsewhere, we will assist you in securing those referrals to the best of our ability. You will be contacted once your application has been reviewed, typically within 2-3 business days of submission. **If you are in need of an emergency appointment, please contact Virginia Beach Psychiatric Center at 757-496-6000 or the emergency line at 911.**

| | Patient Information | | | |
|---|---|---|---|---|
| Legal Last Name | | | Date of Birth | |
| Legal First Name | | | Age | |
| Legal Middle Name | | | Social Security Number* | |
| | | | Marital Status | |
| Street Address | | | | |
| City, State | | | Zip Code | |

*Social Security Numbers are required to file insurance

| Contact Information | |
|---|---|
| Best Contact Number | |
| Secondary Contact Number (if applicable) | |
| Email Address (if applicable) | |

*Please inform staff or your provider if you DO NOT want phone call reminders of your upcoming appointments

| Emergency Contact | |
|---|---|
| Name of Emergency Contact | |
| Relationship to Emergency Contact | |
| Emergency Contact Phone Number | |

| Referral Information | |
|---|---|
| Were you referred by another office or provider? | |
| By whom were you referred? | |
| Name of provider to whom you were referred (if applicable) | |
| How did you hear about our practice, if not referred directly? | |

When assigning your provider(s), it is ethically mandated that clinicians avoid significant conflicts of interest when working with their patients. If you are aware of any family members or significant others that are provided services in our office, please list them, and their relationship to the applicant, below:

| Name of other individual seen at this office | Relationship to the applicant | Clinician working with the other patient (if known) |
|---|---|---|
| | | |
| | | |

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Please provide your insurance card and photographic identification at the time of your appointment. Copies will be made of both items for clinical records. In the event that your insurance information changes, please update our records as soon as possible. Outstanding balances that result from incorrect insurance information will be the responsibility of the patient. At the time of your first appointment, you will be requested to sign a form that affirms your understanding of office policies and insurance considerations. These additional forms are available on our website.

| **Primary Insurance (or self-pay)** | | | | |
|---|---|---|---|---|
| Name of **Primary Insurance** | | | | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no: |
| Patient's relationship to subscriber: | | | | |

| **Secondary Insurance (If Applicable)** | | | | |
|---|---|---|---|---|
| Name of **Secondary Insurance** | | | | |
| Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no: |
| Patient's relationship to subscriber: | | | | |

| **GUARANTOR (FOR MINORS, IF APPLICABLE)** | | | |
|---|---|---|---|
| Person Responsible for patient: | Birth date: / / | Address (if different): | Home phone no.: ( ) |
| Occupation: | Employer: | Employer address: | Employer phone no.: ( ) |
| Is this patient covered by insurance? | | | |

| Desired Services and Treatment History | |
|---|---|
| Are you seeking medication management? | |
| Are you seeking individual therapy? | |
| Are you seeking family/couples' therapy? | |
| Are you seeking psychological testing (e.g. to evaluate possible ADHD) | |
| Are you court ordered for treatment? | |
| Please provide a brief summary of the nature of the problem(s) for which you are seeking treatment | |
| How long have these concerns been problematic? | |

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| Previous Mental Health Treatment | |
|---|---|
| Have you worked with a mental health provider previously? If so, for medication or therapy? | |
| Are you actively working with any mental health providers? List name of provider(s), if applicable | |
| When were you last actively working with mental health providers? | |
| Have you ever been hospitalized for a mental health concern? | |
| Please note the approximate dates of all psychiatric hospitalizations and the name of the hospital (if applicable) | |
| Have you ever attempted suicide? If so, when? | |
| Do you currently feel suicidal? | |

***If you currently feel suicidal, please contact either Virginia Beach Psychiatric at 757-496-6000 or the emergency line at 911 for more immediate services**

| Active Psychiatric Medications | | |
|---|---|---|
| Medication | Dosage (e.g. milligram) | Frequency |
| | | |
| | | |
| | | |
| | | |

| Medical Background (please leave all non-applicable concerns blank, place a "Y" or "yes" for those concerns that are applicable to your case) | | | | | |
|---|---|---|---|---|---|
| Diabetes | | Kidney Disease | | Liver Disease | |
| Chest pain/Angina | | Cancer | | Pregnancy | |
| High Blood Pressure | | Osteoporosis | | Arthritis | |
| Heart Disease | | Asthma/COPD | | Heart Surgery | |
| Heart Attack | | Stroke/CVA/TIA | | Blood Clots | |
| High Cholesterol | | Seizures | | Peripheral Vascular Disease | |
| Pacemaker | | HIV/AIDS | | Tuberculosis | |
| Headaches | | Hepatitis | | Congestive Heart Failure | |
| Kidney Stones | | Stomach Ulcer | | Thyroid Disease | |
| Other medical concerns (please specify) | | | | | |
| **Please list all medication allergies** | | | | | |

| Additional Active Medications (Non-psychiatric) | | |
|---|---|---|
| Medication | Dosage (e.g. milligram) | Frequency |
| | | |
| | | |
| | | |
| | | |
| | | |

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| Employment/disability | |
|---|---|
| Current Employment (if applicable) | |
| If not currently employed, when were you last employed? | |
| Are you currently on disability? | |
| When were you first placed on disability? | |
| Do you have any pending disability claims? | |
| Are you currently planning on filing for disability? | |

| Legal Involvement | |
|---|---|
| Are you currently involved in any legal proceedings? | |
| Are you currently involved in, or expect to be involved in, child custody proceedings? | |

| Substance Use | |
|---|---|
| How often do you consume alcohol? | |
| Do you have a history of problematic alcohol consumption? | |
| How often do you consume tobacco products? | |
| Do you have a history of problematic tobacco consumption? | |
| How often do you consume marijuana/cannabis? | |
| Do you have a history of problematic marijuana/cannabis consumption? | |
| Do you have a history of using any other recreational substances? Please specify | |

| **If you feel there is any additional information that will help us to establish the best possible services, please specify in the box provided below** |
|---|
| |

Please allow our office staff and new patient coordinator 2-3 business days to review your paperwork and determine the most appropriate provider based upon your case and your active insurance(s). You will be contacted by our staff (at your listed preferred contact number). If, for any reason, we are unable to provide you with your desired services, we will provide additional referrals to local offices that may better be able to assist you.

If you have any further questions, please call our office at 757-461-3313. Thank you.