REGISTRATION FORM

Patient Name (please print)_____
First Last

Address_____
Street City State Zip

Date of birth_____ Gender identity_____

Marital status_____ Preferred pronouns_____

okay to leave messages

Home phone_____ yes____ no_____

Cell phone_____ yes____ no_____

Work phone_____ yes____ no_____

Okay to receive appointment reminders by text message: yes____ no____

Email address:_____

Emergency contact:_____ Relation to patient_____

If patient is a minor:
Parent/Guardian Name_____ Relation to patient_____

INSURANCE INFORMATION

Primary insurance_____

ID_____ Group_____

_____ _____ _____
Name of policyholder DOB Relation to patient

Secondary insurance_____

ID_____ Group_____

_____ _____ _____
Name of policyholder DOB Relation to patient

Assignment of Benefits: By signing below, I authorize MSP Psych Services to bill my insurance company, including Medicare, and for those benefits to be assigned to MSP Psych Services. If insurance does not cover the costs, I understand I will be liable for any and all charges.

Cancellation Policy: Cancellations must be made 24 hours prior to schedule appointment. Cancelled appointments with less than 24 hour notice or a failed appointment may be subject to a fee. By signing below, I acknowledge I understand and agree to this policy.

_____ _____
Signature of patient/guardian Date

Who referred you to MSP Psych Services or how did you hear about us?_____

Mental Health History *(If none, please indicate)*

Name of psychiatrist and clinic:_____

Date of last visit:_____

Reason for leaving:_____

Name of family doctor if they are prescribing psychiatric medication:_____

Name of therapist/counselor and clinic:_____

Diagnosis (e.g. depression, anxiety, ADD, etc.):_____

_____

If you have an ADD diagnosis, when did formal testing occur:_____

Who provided the ADD testing:_____

Past psychiatric hospitalizations (where, when, reason):_____

_____

Past suicide attempts (how many and when):_____

Self-injurious behavior (e.g. cutting on self):_____

Physical, sexual, or emotional abuse:_____

_____

Case worker name and phone number:_____

Medications

Current medication with dosing instructions:_____

_____

Past medication trials and outcome (list medication names):_____

_____

Current pharmacy (name and address):_____

Medical (*If none, please indicate)*

Height:_____ Weight:_____ Currently: Pregnant_____ Breastfeeding_____

Allergies:_____

Current health issues (e.g. asthma, migraines, diabetes, etc.):_____

_____

Past surgeries (include year of surgery):_____

Substance Use

Chemical	Current Use	Past Use	Never Used	Date of last use	Quantity
Alcohol					If current use, how many drinks per week?
Medical Marijuana					If current use, how often is it used?
Drugs (marijuana, heroin, cocaine, meth, etc.)					List drug names and frequency of use:
Opiates (Hydrocodone, Oxycodone, OxyContin, Morphine, etc.)					List opiate names and frequency of use:
Tobacco					

Substance use treatment (facility name & date):_____

Miscellaneous

Family members with mental health issues:

	Diagnosis
Mother	_____
Father	_____
Sister	_____
Brother	_____
Maternal Grandmother	_____
Maternal Grandfather	_____
Paternal Grandmother	_____
Paternal Grandfather	_____
Daughter	_____
Son	_____
Spouse	_____

Family members with chemical dependency issues:

	Alcohol	Drugs
Mother	_____	_____
Father	_____	_____
Sister	_____	_____
Brother	_____	_____
Maternal Grandmother	_____	_____
Maternal Grandfather	_____	_____
Paternal Grandmother	_____	_____
Paternal Grandfather	_____	_____
Daughter	_____	_____
Son	_____	_____
Spouse	_____	_____