

PSYCHOSOMATIC INSTITUTE OF SAN ANTONIO
New Patient Information

Name: Last: _____ First: _____ MI: _____ Birth Date: _____
Sex: M _____ F _____ Marital Status: Single Married Divorced Separated Widowed Partnered Other
Preferred name: _____ Emergency contact:(_____) _____ - _____ Relation: _____
Address: _____ Zip Code: _____
City/State: _____ SS#: _____
Mailing address: _____
Home Phone: _____ Work Phone: _____
Cell: _____ Email _____ @ _____
Race: _____ Ethnicity: _____ Preferred Language: _____
Appointment Reminder #: _____ Circle one: Home Work Cell Other

If Patient is Minor:

Mothers Name: _____ Birth Date: _____ SS#: _____
Address: _____ Phone: _____
Employer: _____ Employer Address: _____
Phone: _____
Fathers Name: _____ Birth Date: _____
SS#: _____ Address: _____
Phone: _____ Employer: _____
Employer Address: _____ Phone: _____

Insurance Information:

Primary Insurance Company: _____ Phone#: _____
Insurance ID: _____ Group#: _____
Policy Holder: _____ Birth Date: _____
SS#: _____

Secondary Insurance Company: _____ Phone#: _____
Insurance ID: _____ Group#: _____
Policy Holder: _____ Birth Date: _____
SS#: _____

Third Party Consent:

I authorize Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA to communicate with my insurance to coordinate treatment, facilitate quality of treatment, and obtain reimbursement. By not signing consent, I am agreeing to full payment at time of service. _____ Initials

I understand and agree that, regardless of insurance status, I am responsible for the balance on this account for any professional services rendered. I certify that the information I have provided is true and correct. I will notify Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA of any changes in the above information, including insurance coverage in a timely manner. _____ Initials

Privacy Notice:

I acknowledge that I have been provided access to Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA notice of privacy practice (NPP). I understand that I can obtain a copy of the NPP from the front desk or website. If I have any questions I understand I can contact PISA/MP privacy officer at 210-541-8455. _____initials

HIPAA:

I acknowledge that I have been provided access to Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA PISA/MPPA, HIPPA notice. I understand that I can obtain a copy of the HIPPA form from the front desk or website. If I have questions I understand I can contact PISA/MPPA privacy officer at 210-541-8455. _____Initials

Office Policies:

I acknowledge that I have been provided access to Psychosomatic Institute of San Antonio/Maldonado Psychiatric PA PISA/MPPA, Office Policies. I understand that I can obtain a copy of the Office Policies form from the front desk or website. If I have questions I understand I can contact PISA/MPPA Office Manager at 210-541-8455. _____Initials

Financial Responsibility:

I _____(Responsible Persons Name), understand the following Psychosomatic Institute of San Antonio/ Maldonado Psychiatric PA financial policies.

- If I or the patient are covered by one or more insurances at the time of Visit, I am responsible for providing that information to Psychosomatic Institute of San Antonio.
- I am responsible for making sure my insurance is aware of my choice of providers.
- Psychosomatic Institute of San Antonio will make every attempt to verify insurance coverage. Verification may take as long as 48 hrs.
- Fees for services **NOT COVERED** by my or patients insurance are my responsibility.
- Copay and Deductibles that are required by my or patients insurance are **due at time of service**.
- **Account balances not paid with in 120 days of service maybe be turned over to collections agency.**

Patients name: (print) _____ Date

Responsible Party (print) _____ Relationship _____ Date

Signature of Responsible Party _____ Date

PSYCHOSOMATIC INSTITUTE
OF SAN ANTONIO
CLINICAL INFORMATION

Name: _____ Date of Birth: _____

Reason for your visit _____

Past Medical history: Do you suffer or have suffered in the past of:
(circle: yes or no)

Parkinson's disease	yes no	Seizures	yes no	Hyperlipidemia	yes no
Multiple Sclerosis	yes no	Glaucoma	yes no	Thyroid disease	yes no
Head injury	yes no	Cancer	yes no	Arthritis	yes no
Migraines	yes no	Hypertension	yes no	Fibromyalgia	yes no
Stroke	yes no	Diabetes	yes no	Gastric disease	yes no
Disabled	yes no	Kidney disease	yes no	Lung disease	yes no
Heart disease	yes no	Chronic pain	yes no		

Other: _____

Please list the name of your physician/psychotherapists and their information if available: Do you want us to share information with them: Yes or No

Primary care physician; _____ phone: _____ fax: _____

Do you want us to send information to your primary doctor(s) Yes or No

Authorizing signature: _____ date _____

Referred to us by: _____

Other physicians by specialty (continue on the back if needed)

List previous hospitalizations or surgeries

Past psychiatric history:

Previous treatments yes no With another psychiatrist yes no

Currently in therapy yes no Previously in therapy yes no

Ever hospitalized for a psychiatric condition: yes no

If yes, how many times _____

When and where were the first and the last hospitalizations

Name and relation of persons living with you now: _____

Other immediate family members not living with you:

Previous medications: (please circle if have taken in the past. Note dose and approximate length of time taken)

Anafranil (clomipramine)
Cymbalta (duloxetine)
Effexor (venlafaxine)
Emsam (selegiline)
Luvox (fluvoxamine)
Nardil (phenelzine)
Pamelor (nortriptyline)
Paxil (paroxetine)
Prozac (fluoxetine)
Savella (milnacipram)
Sinequan (doxepin)
Vivactil (protriptyline)
Viibryd (Vilazodone)
Brintellix (vortioxetine)

Celexa (citalopram)
Desyrel or Oleptro (trazodone)
Elavil (amitriptyline)
Lexapro (escitalopram)
Marplan (isocarboxazid)
Norpramin (desipramine)
Parnate (tranylcypromine)
Pristiq (desvenlafaxine)
Remeron (mirtazapine)
Serzone (nefazodone)
Tofranil (imipramine)
Wellbutrin (bupropion)
Zoloft (sertraline)
Fetzima (levomilnacipran)

Lithium carbonate
Lamictal (lamotrigine)
Topamax (topiramate)
Abilify (aripiprazole)
Latuda (Lurasidone)
Geodon (ziprazidone)
Invega (paliperidone)
Navane (thiothixene)
Perphenazine (Trilafon)
Risperdal (risperidone)
Seroquel (quetiapine)
Triavil (Amitriptyline/perphenazine)
Zyprexa (olanzapine)

Depakote (valproic acid)
Tegretol (carbamazepine)
Trileptal (oxcarbazepine)
Clozaril (clozapine)
Fanapt (iloperidone)
Haldol (haloperidol)
Mellaril (thioridazine)
Orap (pimozide)
Prolixin (fluphenazine)
Saphris (asanepine)
Stelazine (trifluoperazine)
Thorazine (chlorpromazine)

Ambien (zolpidem)
Buspar (buspirone)
Klonopin (clonazepam)
Restoril (temazepam)
Sonata (zaleplon)
Halcion (triazolam)
Adderall (XR) (amphetamine mixed)
Concerta (methylphenidate)
Dexedrine (dextroamphetamine)
Metadate (methylphenidate)
Provigil (modafinil)
Strattera (atomoxetine)
Vyvanse (lisdexamphetamine)
Pain medications (Narcotics)

Ativan (lorazepam)
Dalmane (flurazepam)
Lunesta (Eszopiclone)
Rozerem (ramelteon)
Xanax (alprazolam)
Serax (oxazepam)
Nuvigil – (armodafinil)
Daytrana (methylphenidate)
Focalin (dexmethylphenidate)
Phentermine
Ritalin (methylphenidate)
Intuniv (guanfacine)
Zenzedi (Dextroamphetamine)