North Hills Psychiatry
PATIENT REGISTRATION
Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name (*First, M.I., Last*)____

Date of Birth ____________ Age ____________ Male / Female Marital Status: S M W D

Address ____

Phone: Home: ______________________ Cell: ______________
Preferred method of contact: Home/Cell
Okay to leave message on phone: yes/no

Parent/Legal Guardian name: ______________________ DOB: ______________

Address: ______________________ Relationship: ______________

Phone: Home: ______________________ Cell: ______________
Preferred method of contact: Home/Cell
Okay to leave message on phone: yes/no

Parent/Legal Guardian name: ______________________ DOB: ______________

Address: ______________________ Relationship: ______________

Phone: Home: ______________________ Cell: ______________
Preferred method of contact: Home/Cell
Okay to leave message on phone: yes/no

Employer ______________________________ Phone ______________

Employer Address ____

Referring Physician ____

Reason for visit ____

If Student, School Name ______________________________ Full-Time / Part-Time

How did you hear about us ____

Emergency Contact

Name ______________ Relationship ____________ Phone:______________

Name ______________ Relationship ____________ Phone:______________

In signing this, I agree that all of the information above is correct.

Patient/Legal Guardian Signature ______________________ Date ______________

Patient History

Medical History

Please list any medical diagnosis: ____

____

____

Please circle any that apply:

☐ Cardiac: Heart problems, Hypertension/High blood pressure, Murmur, Hypercholesterolemia
☐ Endocrine: Diabetes T1/ T2, Thyroid problems
☐ Neurological: Seizures, Tremors, Head injury, Loss of consciousness
☐ Musculoskeletal: Movement disorders, Tics, abnormal movements due to medication

Past Surgeries: ____

____

____

Current Medications:
List ALL medications (Name, Dose and Frequency): ___________________________

____

____

Allergies and type of reaction: ____

Psychiatric History

Previous diagnosis: ____

____

____

Past trials of medications: ____

____

____

Past treatment (include any outpatient treatments and hospitalizations, along with reason): __________

____

____

(please use back of paper if additional space is needed)

Aditional Patient History

(Required for Patients that are Minors)

Pregnancy History:	Yes/No	Explanation:
Regular prenatal care		
Medications		
Drugs		
Complications during pregnancy		

Birth History:	Yes/No	Explanation:
Full term pregnancy?		
Cesarean delivery?		
Complications during delivery?		

Developmental History:	Yes/No	Explanation:
Making appropriate eye contact?		
Delay in speech?		
Delay in motor skills/walking?		

Pediatrician:

Doctor: ______________________________ Practice: ______________________________

Address: ______________________________ Phone: ______________________________

Fax (if known): ______________________________

Other Specialists:

Doctor: ______________________________ Practice: ______________________________

Address: ______________________________ Phone: ______________________________

Fax (if known): ______________________________

NORTH HILLS PSYCHIATRY

PATIENT CONSENT TO TREAT

I hereby give my consent to North Hills Psychiatry and authorize him or her to provide my medical treatment. I understand that North Hills Psychiatry will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize North Hills Psychiatry to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously.

I have carefully read and I fully understand this Patient Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

CONFIDENTIALITY

I understand North Hills Psychiatry is committed to the confidentiality of communication with patients. Services provided by North Hills Psychiatry and information I disclose are confidential except as required by state or federal regulation. Personal information I have disclosed may be entered into my clinical records in written form.

Patient Name ______________________________

Patient Signature ______________________________ Date ____________

Parent or Legal Guardian Signature (for minor) ______________________________

Relationship to the Patient ______________________

Signature of Treating Provider ____________________ Date ____________