**Appalachian Psychiatry, PLLC**
**Thomas R. Olmsted, MD**
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276-644-9800 (phone) - 276-644-9808 (fax)

# Patient Registration Form

Name:_____ Date:_____
Date of Birth: _____ Social Security #: _____Sex:M__F__
Address: _____City, State, Zip:_____
Home Phone: _____Cell Phone: _____Work Phone:_____
Employment: Full Time__ Part-Time__ Not Employed__ Self__ Retired__ Military__
Employer:_____ Employer Address:_____
Employer Phone Number:_____ Email Address: _____
Student: Full Time__ Part Time__ Not a student__
Referring Provider: _____ Primary Care Provider: _____
Marital Status: Single__ Married __ Divorced __ Widowed __ Separated __
Do you have advanced directives or a living will? Yes _____ No _____

**Person Responsible for Payment (Guarantor)**

(___Check if same as above, if not please complete below)

Relationship to Patient:_____
Guarantor's Last Name: _____ First Name: _____
Address: _____City, State, Zip:_____
Home Phone:_____Cell Phone: _____Work Phone:_____
Date of Birth:_____Social Security #:_____Sex: M___ F____
Employer: _____ Employer Phone #:_____
Employer Address:_____

**Insurance Information**

*Primary* Insurance Name: _____ Effective Date:_____
Subscriber Name:_____ Policy Number:_____
Group Name/Employer:_____ Group #:_____
Policy Phone #:_____Patient's Relationship to Subscriber:_____
Subscriber Date of Birth:_____
*Secondary* Insurance Name: _____ Effective Date:_____
Subscriber Name:_____ Policy Number:_____
Group Name/Employer:_____ Group #:_____
Policy Phone #:_____Patient's Relationship to Subscriber:_____Subscriber Date of Birth:_____

**IN CASE OF EMERGENCY CONTACT**:

Name: _____ Relationship to Patient:_____

Name:

Home Phone:_____
Cell Phone:_____
Work Phone:_____
Name: _____ Relationship to Patient:_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____

**Pharmacy Information**

(If you have a prescription benefit plan, please present this to the receptionist. )
Pharmacy: _____
Phone Number:_____
Mail-Order Pharmacy: _____

**Privacy Acknowledgment**

1. May we call the phone numbers you provided and leave a message on an answering machine or with a family member/friend your appointment or test results? Yes___No ___
If no, is there a phone number that you prefer we try to reach you? _____
2. May we mail information regarding your appointments or test results to the address you provided? Yes ____ No ____
If no, is there an address that you prefer we send information to?
_____
3. Do you wish us to share health information regarding you with a family member or friend? Yes ___ No ____ If yes, please specify the name(s) of the individual(s).
_____
_____

4. May we contact you via email with information about our practice, educational programs, and general health information? Yes ___ No ___ If yes, I understand that email transmissions may not be secure and will not be used for the purpose of communicating my personal health information.

NOTE: In order to provide the utmost protection of your health information, we reserve the right to use professional judgment and discretion when communicating information/test results which may be “sensitive” in nature.

I have received a copy of Appalachian Psychiatry’s HIPPA Policy.

**Consent to Treat**

Name:

I authorize the physicians to administer such treatment as they may deem advisable for diagnosis and treatment. I certify that I have been made aware of the role and services offered by the physician and I consent to care by such provider. I understand that these services are voluntary and that I have the right to refuse these services. I agree and consent to the withdrawal and testing of my blood, without further consent by me, in the event that there is accidental blood borne pathogen exposure to any medical, nursing, or other clinical staff, in order to test such blood for the presence of Hepatitis B virus or HBV, Hepatitis C virus or HVC, and Human Immunodeficiency or HIV. I understand and agree that the results of such laboratory testing shall be maintained confidential, except to my treating healthcare providers, any clinical staff so exposed, and as may be allowed by any applicable state or federal statue, regulation, or rule of law.

This means that if any medical practice personnel or physicians are exposed to my blood through a needle stick, blood splash, or other means while I am being treated, I agree to allow my blood to be drawn and tested for HIV or Hepatitis. The results will be kept confidential except to my physician, any healthcare personnel caring for me, the medical practice personnel exposed or as required or allowed by law. This will be at no charge to me.

## Financial Agreement

I understand and agree, that regardless of my insurance coverage, I am ultimately responsible for payment of any charges for professional services rendered. I understand that I will be ultimately responsible for collection of fees and any attorney fees should my account be placed within a collection agency due to nonpayment of my account. I certify that the information I have given is true and correct to the best of my knowledge.

I authorize Appalachian Psychiatry to release any and all medical and billing information to any health care provider involved in my treatment and to any health care facility directly or indirectly involved in my treatment for purposes including, but not limited to, billing, collection, quality assurance or risk management activities, or defense of litigation or anticipated litigation and to any insurance company, health maintenance organization or other entity which is directly or indirectly responsible for payment or review of services provided by Appalachian Psychiatry.

## Medicare & Medicaid

I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for covered Medicare services to the physician.

BY SIGNING & DATING BELOW, I ACKNOWLEDGE NOTICE AND RECEIPT OF THE ABOVE INFORMATION PRIOR TO TREATMENT

Patient/Auth. Representative Signature_____ Date:_____
If Authorized Representative, Relationship to Patient:_____
If person other than patient is responsible for payment:
Guarantor Signature:_____Date:_____

## Prescription Monitoring Program

Name:

Patient Name:_____Date of Birth:_____

This authorizes __Thomas R. Olmsted, MD/Mary Catherine W. Olmsted, M.D. to request and receive from the Virginia Department of Health Professions any and all records held by the Department relating to Schedule II-IV controlled substances dispensed to the patient named above.

I understand that this authorization permits the Department of Health Professions to disclose confidential health care records to the prescriber named above. A copy of this authorization shall be included with my original records. There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure as permitted or required by law.

I understand that this consent will remain in effect unless specifically revoked by you in writing.

Patient Signature:_____Date:_____

Guardian Signature:_____Date:_____

Note: This form is in addition to and separate from any other disclosure forms that you may have signed.
Note: If you are over the age of eighteen, you may request your own information from the prescription monitoring program at http://www.dhp.virginia.gov

**Medical History:**

*Current Medications* *Dose* *How Often*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

(If needed, use the back of this paper to list more medications)

*Medication Allergies*: _____
_____
_____
_____
_____

Name:

Current Medical Problems: *Please check any condition that you have or have had and write any below that are not listed; Place an 'F' next to any illness of which there is a family history*

___Thyroid Disease
___Anemia
___Liver Disease
___Fibromyalgia
___Chronic Fatigue
___Heart Disease
___Diabetes
___Asthma/COPD/Respiratory Problems
___Stomach or Intestinal Problems
___Cancer
___Alcohol/Substance Abuse
___Depression
___Bipolar Disorder
___Psychosis
___Anxiety
___Panic Attacks
___Epilepsy or Seizures
___Chronic Pain
___High Cholesterol
___High Blood Pressure
___Head Trauma
___Suicide (Family History)

Other: (Use back if necessary) _____

_____

_____

Past Medical Problems: _____

_____

_____

Surgeries: _____

_____

Do you have any pain? Yes ____ No ____

If Yes, where is your pain located? _____

Date of last Complete Physical Exam: _____

Last EKG: _____ Last Labs: _____

*For Women Only*:

Date of Last Menstrual Period: _____

Are you pregnant? Yes ____ No_____

Are you planning on becoming pregnant in the near future? Yes _____ No____

Birth Control Method _____

**Psychiatric History**:

| *Previous Diagnosis* | Dates Treated | By Whom |
|---|---|---|
| | | |
| | | |

| *Psychiatric Hospitalizations* | Dates | Facility |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Are you currently receiving professional counseling or any kind of psychotherapy?
Yes ____ No____ If Yes, by whom? _____

Name:

How many caffeinated beverages do you drink per day? _____

*Tobacco History*: Cigarettes – Now? Yes ___ No ___ In the Past? Yes ___ No ___
How many per day? _____ For how many years? _____
Pipe, Cigars, Chewing Tobacco– Now? Yes___No___ Past? Yes___No_
How often per day? _____ For how many years? _____

## **Psychiatric Medications**

Please place a check mark next to each of the medications that you are taking or have taken in the past.

*Tri-Cyclic Antidepressants*:

____ amitriptyline (Elavil)
____ clomipramine (Anafranil)
____ nortriptyline (Pamelor)
____ protriptyline (Vivactyl) $$
____ amoxapine (Asendin)
____ desipramine (Norpramin)
____ doxepin (Sinequan)
____ trimipramine (Surmontil)
____ imipramine (Tofranil)

*Tetracyclic Antidepressants:*

____ maprotiline
____ mirtazapine (Remeron)
____ trazodone (Desyrel)

*SSRI Antidepressants*:

____ fluoxetine (Prozac)
____ paroxetine (Paxil, Paxil CR)
____ citalopram (Celexa)
____ vortioxetine (Brintellix)
____ levomilnacipran (Fetzima)
____ fluvoxamine (Luvox)
____ sertraline (Zoloft)
____ escitalopram (Lexapro)
____ vilasodone (Viibryd)

*SNRI Antidepressants*:

____ buproprion (Wellbutrin)
____ duloxetine (Cymbalta)
____ milnacipran (Savella) [for fibromyalgia]
____ desvenlafaxine (Pristiq)
____ venlafaxine (Effexor)

*MAOI*:

____ phenelzine (Nardil)
____ selegeline (Deprenyl, Emsam patch)
____ tranylcypromine (Pamate)
____ isocarboxazid (Marplan)

*Mood Stabilizers*:

____ lithium
____ valproic Acid (Depakote)
____ topiramate (Topamax)
____ lamotrigine (Lamictal)
____ carbamazepine (Tegretol)
____ oxcarbazepine (Trileptal)

Name:

____ gabapentin (Neurontin)

*AntiPsychotics*:

____ quetiapine (Seroquel)
____ olanzapine (Zyprexa)
____ risperidone (Risperdal)
____ chlorpromazine (Thorazine)
____ fluphenazine (Prolixin)
____ haloperidol (Haldol)
____ Olanzapine/Fluoxetine (Symbyax)
____ iloperidone (Fanapt)
____ loxapine (Loxitane)
____ thiothixene (Navane)
____ prochlorperazine (Compazine)
____ ziprasidone (Geodon)
____ aripiprazole (Abilify)
____ clozapine (Clozaril)
____ thioridazine (Mellaril)
____ trifluoperazine (Stelazine)
____ asenapine (Saphris)
____ lurasidone (Latuda)
____ paliperidone (Invega)
____ pimozide (Orap)
____ perphenazine (Trilafon)

*Anti-Anxiety/Benzodiazepines*:

____ alprazolam (Xanax)
____ diazepam (Valium)
____ estazolam (Prosom)
____ chlordiazepoxide (Librium)
____ hydroxyzine (Vistaril)
____ clonazepam (Klonopin)
____ lorazepam (Ativan)
____ oxazepam (Serax)
____ busprirone (Buspar)

*Sleep Agents*:

____ ramelteon (Rozerem)$$
____ zaleplon (Sonata)
____ temazepam (Restoril)
____ flurazepam (Dalmane)
____ diphenhydramine (Benadryl, Nytol, Sominex)
____ clorazepate (Tranxene)
____ zolpidem (Ambien)
____ eszopicolone (Lunesta)
____ triazolam (Halcion)
____ melatonin
____ secobarbitol (Seconal)

*Stimulants/ADHD/Memory*:

____ methylphenidate (Ritalin, Concerta, Focalin)
____ amphetamine/dextroamphetamine (Adderall)
____ atomoxetine (Strattera)
____ modafinil (Provigil)
____ dextroamphetamine (Dexedrine)
____ donepezil (Aricept)
____ memantine (Namenda)
____ rivastigimine (Exelon)
____ galantamine (Razadyne)
____ (Vyvanse)

*Seizure medications:*

____ pregabalin (Lyrica)
____ zonisamide (Zonagram)
____ phenytoin (Dilantin)
____ levotiracetam (Keppra)
____ phenobarbital
____ ethosuxamide (Zarontin)

*Parkinson drugs:*

____ benztropine (Cogentin)
____ trihexyphenidyl (Artane)
____ amantadine (Symmetrel)

Name:

*Others (include any herbals:*
____ SAMe ____ metoclopramide (Reglan)

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Please list the problems that are most problematic at present and for which you wish to be seen for today:

1._____
2._____
3._____

What are your goals for treatment? _____
_____
_____
_____