INTAKE FORM-----Bernard Member, MD

DATE______________________

LAST NAME___________________________ **FIRST NAME**___________________________

DATE of BIRTH________________________ **AGE**_____________

ADDRESS____
____

PHONE **HOME**____________________________ **CELL**_____________
____

EMAIL____
____

CONTACT PERSON/PHONE
____

PHARMACY (name & address)____

INSURANCE (Name)____

____
____

REFERRED BY________________________

ACCOUNT GUARANTOR (If patient, just write "self"):

Name, Address, Phone, Relationship ____
____

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____

POLICIES

If you cancel your appointment without 1 day notice, the charge is $50.

The returned check fee is $35.

Please notify the office of address, phone or insurance changes.

MEDICAL INFORMATION

SERIOUS MEDICAL (not Psychiatric) PROBLEMS:

____

CURRENT PSYCHIATRIC MEDICATIONS/DOSES:

____

PAST & CURRENT DRUG or ALCOHOL USE:

____

FAMILY HISTORY of MENTAL ILLNESS:

____

PREVIOUS PSYCHIATRIC HOSPITALIZATIONS:

PAST PSYCHIATRIC DIAGNOSES:

CURRENT SYMPTOMS & REASON FOR THIS APPOINTMENT: