

Raleigh Psychiatric Associates, P. A.
3900 Browning Place, Suite 201 • Raleigh, NC 27609
Telephone 919-787-7125 Fax 919-781-9952

James E. Ballard, M.D.,P.A.
Thomas R. Spruill, M.D.,P.A.
Philip L. Hillsman, M.D., F.A.P.A.
Cherry Chevy, M.D.
Rhonda H. Stahl, M.D.

Zachary. W. Feldman, M.D.
Alyssa Williams George, M.D.
Dana C. Fennell, M.S.N., R.N., C.S.
Frank D. Castlebury, Ph.D
Asa Cordle, M.D. P.A.
Pamela F. Stephenson, Office Supervisor

RALEIGH PSYCHIATRIC ASSOCIATES (RPA)
PATIENT INFORMATION

PLEASE PRINT CLEARLY

DATE _____

PATIENT
NAME _____

LAST

FIRST

M

MAIDEN NAME

ADDRESS _____

STREET

CITY

STATE

ZIP CODE

SOCIAL SECURITY# _____ SEX: M F AGE _____ DATE OF BIRTH _____

OCCUPATION _____ EMPLOYER _____

HOME PHONE: _____ BUSINESS PHONE: _____ CELL: _____

SINGLE MARRIED WIDOWED DIVORCED SEPARATED OTHER _____

SPOUSE, PARENT, SIGNIFICANT OTHER (circle one) NAME: _____

ADDRESS: (if different) _____ PHONE: _____

INSURED'S NAME _____ DATE OF BIRTH _____

OCCUPATION: _____ EMPLOYER: _____ PHONE: _____

CHILDREN OR SIBLINGS (circle one) NAME & AGES _____

PRIMARY PHARMACY: _____ PHONE: _____

REFERRED BY: _____ PRIMARY PHYSICIAN: _____

I GRANT PERMISSION TO SEND LETTERS & SPEAK TO REFERRING CLINICIAN, REQUEST PRIOR

TREATMENT RECORDS & COORDINATE CARE: YES: NO:

Raleigh Psychiatric Associates, P. A.
3900 Browning Place, Suite 201 • Raleigh, NC 27609
Telephone 919-787-7125 Fax 919-781-9952

IN CASE OF EMERGENCY NOTIFY: _____

PHONE _____ RELATIONSHIP: _____

I HAVE A HEALTH CARE POWER OF ATTORNEY: YES: NO:

OTHER CONTACTS WITH PSYCHIATRIST, PSYCHOLOGISTS, SOCIAL WORKER, MENTAL HEALTH
COUNSELORS OR HOSPITALIZATIONS: _____

PERSON RESPONSIBLE FOR BILL IF OTHER THAN PATIENT:

NAME: _____ RELATIONSHIP: _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____
PHONE _____

NAME OF HEALTH INSURANCE _____

NAME OF POLICY HOLDER: _____ POLICY HOLDER DOB _____

SUBSCRIBER ID # _____ GROUP # _____ EFFECTIVE DATE _____

I agree I am responsible for all medical expenses I incur at RPA regardless of what my insurance carrier decides or reimburses. If any overpayment of my account, a refund will be issued or credit to future visits.

I authorize the physician/therapist to provide treatment as is necessary.

I authorize release of medical information to my primary physician.

I authorize the release of medical information to my insurance carriers.

I understand RPA is an interdisciplinary group practice where clinicians share medical records and on-call responsibilities. I understand my clinicians may recommend the services of another RPA clinician to collaborate, consult, and/or coordinate my care.

Raleigh Psychiatric Associates, P. A.
3900 Browning Place, Suite 201 • Raleigh, NC 27609
Telephone 919-787-7125 Fax 919-781-9952

I understand that in so doing, clinicians need to share information about me. The clinicians and staff at RPA do not, as a routine, accept e-mail. Each clinician may choose to make exceptions. Should this occur, then this agreement acknowledges this arrangement and will be a part of the clinical record as will copies of all the e-mails. All phone calls are part of the record.

I understand that I must give a 24 Hour Notice for cancellation of appointment weekdays and Friday by 12:00 noon for Monday or I will be charged a regular fee. I have read and understand and so indicate.

Patient (or authorized agent) Signature

Date

I authorize my insurance benefits to be paid directly to the designated physician or therapists if they are participating and in network.

Patient (or authorized agent) Signature

Date

MEDICAL AND SURGICAL HISTORY FORM

Patient's Name (Please Print)

Date

Please list all medical illnesses:

Please list all surgeries including the year surgery was performed:

Please list medical and psychiatric illnesses in your family including the family connection:

Raleigh Psychiatric Associates, P. A.
3900 Browning Place, Suite 201 • Raleigh, NC 27609
Telephone 919-787-7125 Fax 919-781-9952

Patient's Name (Please Print)

Date

REVIEW OF SYSTEMS

Constitutional: fever weight gain weight loss appetite change night sweats fatigue
chills

Eyes: blurry double vision vision loss tearing redness pain sensitivity to light
glaucoma

Ears, Nose, Mouth, Throat: hearing loss ringing ears ear pain nasal congestion nasal
drainage nosebleeds mouth/throat irritation tooth problem

Cardiovascular: chest pain/pressure heart racing palpitations sweating leg swelling
high/low blood pressure

Pulmonary: cough yellow/green sputum blood in sputum shortness of breath wheezing

Gastrointestinal: nausea vomiting diarrhea constipation pain blood in stool or
vomit heartburn difficulty swallowing

Genitourinary: incontinence abnormal bleeding abnormal discharge urinary frequency
urinary hesitancy pain impotence sexual problem infection urinary retention

Musculoskeletal: pain stiffness joint redness/warmth arthritis back pain weakness
muscle wasting sprain/fracture

Neuro: headache weakness dizziness change in voice change in taste change in vision
change in hearing loss/change sensation trouble walking balance problem coordination
problem shaking speech problem

Endocrine: cold or heat intolerance blood sugar problem weight/gain loss missed periods
hot flashes/sweats change in body hair change in libido increased thirst increased
urination

Heme/Lymph: swelling bleeding problem anemia bruising enlarged lymph node

Allergic/Immunologic: itch post nasal drip watery/itchy eyes nasal drainage
immunosuppressed