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

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RALEIGH PSYCHIATRIC ASSOCIATES (RPA)

PATIENT INFORMATION (PATIENTS UNDER 18)

PLEASE PRINT CLEARLY DATE: _____

Person Filling Out Form: _____ Relationship: _____

Patient Name:_____
Last First Middle

Date of Birth:_____ Age: _____ Gender: M ☐ F ☐

Address:_____
Street City State Zip Code

Phone: (H)_____ Mother's Cell:_____ Father's Cell:_____
On which of these phone numbers may we leave a message?
_____

Mother's Name: _____
Last First Middle

Father's Name: _____
Last First Middle

Parents' Marital Status (circle): married separated divorced never married other

If parents are not married or if there is a non-parent guardian, what is the custody arrangement?

_____

_____

_____

_____

PLEASE COMPLETE REVERSE SIDE

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Siblings(Name/Age):_____

Insured's Name: _____ DOB _____

Occupation:_____ Employer:_____

Referred By:_____ Primary Physician: _____

Other contacts with mental health providers (psychiatrists, psychologists, therapists, counselors, hospitalizations):_____

_____

_____

_____

I grant permission for my provider at R.P.A. to correspond and share clinical information with my (please initial) ____referring provider, ____current mental health treatment providers, ____ primary care physician.

Pharmacy:_____ Phone Number:_____

PERSON RESPONSIBLE FOR BILL:

Name:_____ Relationship:_____

_____

STREET ADDRESS CITY STATE ZIP CODE PHONE

NAME OF HEALTH INSURANCE_____

NAME OF POLICY HOLDER: _____ POLICY HOLDER DOB:_____

SUBSCRIBER ID #_____GROUP #_____ EFECTIVE DATE_____

I agree that I am responsible for all medical expenses incurred for my child's treatment at RPA regardless of what my insurance carrier decides or reimburses. If there is any overpayment of my account, a refund will be issued or credit will be put toward future visits.

I authorize the physician/therapist to provide treatment to my child as deemed necessary.

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I authorize release of medical information to my child's other treatment providers as indicated on previous page.

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

I understand RPA is an interdisciplinary group practice where clinicians share medical records and on-call responsibilities. I understand my child's clinicians may recommend the services of another RPA clinician to collaborate, consult, and/or coordinate my child's care. I understand that in so doing, clinicians need to share information about patients.

The clinicians and staff at RPA do not, as a routine, accept e-mail. Each clinician may choose to make exceptions. Should this occur, this arrangement will be a part of the medical record as will copies of all e-mails. Notes from all telephone calls and copies of faxes sent and received will also be included in the medical record.

I understand that I must give **24 Hours' Notice** for cancellation of appointments Tuesday through Friday, and **by 12:00 noon on Friday** for cancellation of an appointment the following Monday or I will be charged a regular fee.

_____ _____

Signature of Parent/Guardian Date

I authorize my child's insurance benefits will be paid directly to the designated physician or therapist if they are participating and in-network for my insurance plan.

_____ _____

Signature of Parent/Guardian Date

Adopted:7/2004 Revised 7/2016

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MEDICATION HISTORY

PATIENT NAME: _____DATE: _____

For our records, please list: 1) Any known allergies, 2) all medications, both over-the-counter and physician prescribed, you are taking now or have taken during the last six months, and 3) any psychiatric medications (antianxiety, antidepressant, antimanic, antipsychotic, tranquilizer) you have ever taken.

ALLERGIES: _____

_____

MEDICATION NAME	STRENGTH (mg)	DOSAGE & FREQUENCY	M.D. WHO PRESCRIBED	DATES TAKEN FROM	TO	REASON FOR TAKING	EFFECTIVENESS OR PROBLEMS

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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:

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_____ _____

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 vomitus 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