J C Center for Psychiatric Services
43200 Dequindre Rd., Suite 104
Sterling Heights, MI 48314
Phone: (586) 799-4350
Fax: (586) 799-4279

NEW PATIENT REGISTRATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____ Cellular Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Relationship (e.g. Spouse, Mother, etc.): _____

INSURANCE SUBSCRIBER INFORMATION:

Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____

Social Security Number: _____

Employer Name: _____ Employer Phone: _____

Employer Street Address: _____ City, State, Zip: _____

Primary Insurance Company Name: _____ ID #: _____

Group #: _____ Insurance telephone #: _____

Secondary Insurance Company Name: _____ ID #: _____

Group #: _____ Insurance telephone #: _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process this claim.
I hereby authorize Dr. Mekhael to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. Mekhael. I certify that the information I have reported with regard to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ Date: _____

Silver Oak South
43200 Dequindre Rd., Suite 104
Sterling Heights, MI 48314
Phone: (586) 799-4350
Fax: (586) 799-4279

EVALUATION INFORMATION

What is the reason for today's visit? _____

Who referred you to this clinic? _____

Previous psychiatrist(s): _____

Current therapist and frequency of therapy: _____

Previous psychiatric hospitalizations (list places and dates): _____

Previous medications for mental/behavioral health: _____

MEDICAL HISTORY AND INFORMATION

List any allergies to medications and the reaction that occurs: _____

Current medications (list all): _____

_____

Primary care physician and name and specialty of any other physician(s) treating you: _____

_____

List any previous surgeries or hospitalizations: _____

Do you smoke? □ No □ Currently: _____ packs per day □ Previously: _____ packs per day
Do you regularly drink alcohol? □ No □ Yes: _____ drinks per day
Do you regularly smoke marijuana? □ No □ Yes
Other drug use? □ No □ Yes
Females only: Are you pregnant, planning a pregnancy, or breastfeeding? □ No □ Yes
Have you ever had any of the following? (check all that apply)

- □ Arthritis
- □ Asthma
- □ Blood disorders
- □ Blood in stool
- □ Broken bones
- □ Cancer
- □ Chest pain
- □ Chronic pain
- □ Diabetes
- □ Dizziness
- □ Eczema
- □ Glaucoma
- □ Headaches
- □ Hearing difficulties
- □ Heart attack
- □ Hepatitis
- □ High blood pressure
- □ Kidney problems
- □ Liver problems
- □ Loss of consciousness
- □ Seizures
- □ Shortness of breath
- □ Skin disorders
- □ Stroke
- □ Tuberculosis
- □ Memory loss
- □ Vision changes
- □ Weakness
- □ Weight changes

The information above is correct to the best of my knowledge.

Signature: _____ Date: _____