Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

Name: _____ **DOB:** _____

Gender: MALE FEMALE **Social Security #:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Numbers:

Home: ( ) _____ Can we call you at Home? Yes No

Cell: ( ) _____

Work: ( ) _____ Can we call you at Work? Yes No

Email: _____

Marital Status (circle one): Single Married Divorced Separated

Race (circle one):

American Indian or Alaska Native	Black/African American	Chinese
Filipino	Guamanian or Chamorro	Korean
Hispanic White	Japanese	Other Asian
Native Hawaiian	Other Pacific Islander	Samoan
White/Caucasian	Other Race	

Ethnicity (circle one):

Cuban	Mexican/Mexican American	Not Hispanic or Latino
Other Hispanic or Latino	Puerto Rican	

Preferred Language (circle one):

English Spanish Chinese Italian Polish Russian French Turkish Other

Known Allergies: _____

Employer: _____ **Occupation:** _____

Are you a Student? Yes No **If yes, Name of School:** _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Primary Care Physician: _____ **Phone #:** _____

Address: _____

Therapist Name: _____ **Phone #:** _____

Discipline: _____

Preferred Pharmacy Name: _____ **Phone #:** _____

Pharmacy Address: _____

EMERGENCY CONTACT:

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

Name: _____**Relationship:** _____

Address: _____ **City:** _____ **Zip:** _____

Phone Number: (H)_____**(C)**_____

PRIMARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

SECONDARY INSURANCE:

Insurance Plan: _____ **Policy #:** _____

Policy Holder: _____ **Relation to Patient:** _____

Policy Holder DOB: _____ **Policy Holder SS#:** _____

For Partial Hospitalization Clients Only

Will you be driving to the program? _____

Make/Model/Plate #: _____

THIS FORM IS NOT A PART OF THE PERMANENT RECORD

OUTPATIENT BEHAVIORAL HEALTH SERVICES
NEW PATIENT FORM

Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

OM1000

OP Psychiatric MD Service

170 N. Country Road, Suite 3, Port Jefferson, NY 11777
Phone: (631) 928-3122 Fax: (631) 928-3192

Patient Name:_____DOB: _____

Presenting Problem(s): Please describe your reason for seeking help from a psychiatrist at this time (include date/month/year the problem started, any ideas about hurting yourself or others)?

_____
_____
_____
_____
_____

Was there an event which made these problems or issues surface: Yes No
If yes, please explain:

_____
_____
_____

Please indicate how your problems are affecting the following areas:

Category	Level of Impact				
	No Effect	**Mild Effect**	**Moderate**	**Marked**	**Extreme**
Marriage/Relationship/Family	1	2	3	4	5
Job/ School/Performance	1	2	3	4	5
Friendships/Peer Relationships	1	2	3	4	5
Financial Situation	1	2	3	4	5
Hobbies/Interest/Play	1	2	3	4	5
Physical Health	1	2	3	4	5
Activities of Daily Living	1	2	3	4	5
Sexual Functioning	1	2	3	4	5
Ability to Concentrate	1	2	3	4	5
Ability to Control Temper	1	2	3	4	5

Eating Habits:
Weight Loss _____lbs; Weight Gain _____lbs Current Weight _____lbs
Height _____

Sleeping Habits: (Please check if applicable)
_____ Difficulty Sleeping _____ Difficulty Staying Asleep _____Early Morning Awakening

For Children and Adolescents Only:
Are the child immunizations up to date? _____Yes _____ No
Is the child attending school? ____ Yes _____No Developmental Age: _____
If Yes: Grade: _____

Describe any difficulty in school if any: _____
_____

All Patients please describe the following:
Environment and Home:
How many people live in your household? _____ Is your home safe: _____
Your home is a _____ Single Family House _____ Apartment _____ Duplex
_____ Community Resident _____ Boarding House

Family Members:
List members of your family that live with you: _____
_____
List close family members who you rely on for support: _____
_____

Leisure and Recreation:
What do you do for leisure and recreation? _____

Childhood History:
Are there any significant events from your childhood (i.e. Physical abuse, verbal abuse, sexual abuse, deaths of significant people, illness, surgeries, injuries? _____
_____

Military Service:
Have you served in the military? _____ Branch: _____

Financial Status:
Do you have any serious financial problems? (I.e. Bankruptcy, lawsuits?)
_____

Current Abuse:
Are you currently the victim of sexual or physical abuse? _____

Cultural Heritage:
What is your ethic background? _____
What is your religion? _____

Medical History:
Allergies: _____
Do you have pain now? _____ No _____Yes;
Have you had pain in the recent past? _____Yes _____No
Please list any past or present medical or surgical conditions that you have been treated for:

_____
_____
_____
_____

When did you last have a physical examination? _____

Habits:	Amount Currently Using	Most Ever Used
Coffee (cups/day)	_____	_____
Cigarettes (packs/day)	_____	_____
Alcohol	_____	_____

Family History:
Describe a medical or psychiatric conditions of your parents or siblings:

_____
_____
_____

Psychiatric History:
Have you ever received psychiatric or psychological treatment of any kind before?
_____Yes _____No
If you checked yes to the above question, please answer the following:
What type of care did you receive?
_____Inpatient (hospital) _____Outpatient _____Both _____Partial
When were you in treatment? _____
Where were you in treatment? _____
How long were you in treatment? _____
Who was your provider? _____
Did your doctor prescribe medication at that time? _____Yes _____No
If Yes, what medication (please provide dosages:

_____
_____
If you were on medication what worked best for you? _____

Substance Abuse History:

Have you ever abused drugs or alcohol? _____Yes _____No

If yes, please describe Substance Amount When (First use; Last Use)

_____

_____

_____

_____

If yes, have you ever received substance abuse treatment of any kind? _____ Yes _____No

If yes, what is the treatment setting? _____

Do you have any black outs, seizures, or withdrawal symptoms? _____Yes _____No

Legal Issues:

Do you have any legal charges against you? _____Yes _____No

Are you on probation? _____Yes _____No

Do you have any court dates in the near future? _____Yes _____No

Please describe anything else you would like your clinician to know?

_____

_____

_____

_____

_____

_____ _____ _____

Signature Date Time

Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

MS4365

Patient Name: _____ Date of Birth: _____

Please list below any medications that you are currently taking for medical and psychiatric illnesses, and the name of the practitioner who prescribes them. Please include any over the counter medications, herbal remedies or dietary supplements.

Medication	Dose	Route	Directions	Prescriber

Form Completed By: _____ Date: _____

Mather Hospital • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

CS4408

Name of Patient: _____

I hereby give my consent to receive professional psychiatric services at this office.

I understand my rights to:

1. Competent and timely treatment delivered in a respectful manner from a trained mental health professional.
2. Participate in the development of my plan of care.
3. Expect that my communications are to be treated in a confidential manner. I will determine to whom any information will be released and this will occur only with my signed consent. I am aware that under certain circumstance information can be released without consent. This could occur if my record is requested by a court of law in the form of a subpoena, in response to a medical emergency, to a third party payer, insurance company or in response to a state or federal mandatory statuary or regulatory agency. I consent to the guarantor on my account to receive information regarding billing and payment for the services that I receive.
4. Have the opportunity to inspect my medical record in the presence of a staff member to assist in the interpretation of its contents.
5. I acknowledge receipt of the Privacy Notice outlining my rights regarding confidential protected health information.

I understand and agree with the responsibilities to:

1. Actively and earnestly cooperate with treatment by providing the necessary information and cooperating with the therapeutic interventions recommended by my treatment provider.
2. Keep scheduled appointments, or if it is necessary to cancel an appointment to notify the Office 24 hours in advance so that the time may be allotted to another client. Failure to keep 3 appointments in a 12-month period will result in my treatment provider withdrawing from further professional attendance to me.
3. Pay for treatment services at the time they are delivered. If covered by an insurance plan that my provider is "in network" with, I will be responsible for the applicable copay and deductible that is determined by my insurance company.
4. Smoking is not permitted inside or outside of the building.
5. Conduct myself in a respectful manner towards all staff members.
6. Honor this commitment, as failure to comply will result in my treatment provider withdrawing from further professional attendance to me.

If you have any questions about these statements, our office personnel will discuss them with you. Your signature indicates your agreement with these statements and that you have received a copy of this form.

If you have any complaints about your care, please direct them to the Assistant Vice President of Behavioral Health Services, John T. Mather Memorial Hospital, 75 North Country Rd., Port Jefferson, New York 11777 or call (631) 473-1320 x 5307.

_____	_____	_____
Patient Signature (18 years or older)	Date	Time
_____	_____	_____
Parent or Guardian Signature	Date	Time
_____	_____	_____
Witness Signature	Date	Time

OP PSYCHIATRIC MD SERVICE CONSENT FOR TREATMENT AND STATEMENT OF RIGHTS AND RESPONSIBILITIES

MATHER
JOHN T. MATHER MEMORIAL
HOSPITAL

Outpatient Psychiatric MD Services

170 N. Country Rd, Suite 3, Port Jefferson, NY 11776
Telephone Number: (631) 928-3122 Fax Number: (631) 928-3192

FINANCIAL RELEASE AND ASSIGNMENT

I, the undersigned have insurance coverage with _____ an assign directly to my physician/provider, _____ medical benefits, if any payable to me for services rendered.

I understand I am financially responsible for all charges incurred, as well as co-pats, deductibles and non-covered services as determined by my insurance carrier, I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____
Signature of Insured/Guardian

_____
Date