PATIENT INFORMATION

Please provide us with the current information below so we can keep your file accurate and up to date. We request that you please print the information legibly. Thank you for your cooperation.

PATIENT INFORMATION

Last Name: ____________________ First Name: __________________ MI:____________________

Date of Birth: _________________ Age: _______ Social Security Number _____________________

Sex M or F Other__________________ Maiden Name (if applicable) __________________________

Current Mailing Address: ________________________________

City: ___________________ State: ____________ Zip ____________ Email:_________________________________

Cell Phone: ____________ Home Phone: _____________

Employer: ______________________ Work Phone: __________________

MARITAL STATUS (circle one): Married Single Divorced Widowed Legally Separated Life Partner

Race: __White/Caucasian ___African American___ Native American___ Alaskan Native ___Asian ___Hispanic/ Latino __Non-Hispanic Latino___ Pacific Islander ___Other, Not Listed

Ethnicity: __Mexican __ Puerto Rico___ Cuban ___Other Hispanic ___Not Hispanic __African American ___Native American ___White/Caucasian ___African ___European___ Other Not Listed ___Unknown

PARENT/LEGAL GUARDIAN INFORMATION

Last Name: ____________________ First Name: __________________ MI:____________________

Date of Birth: ____________ Relationship to Client: ___________ Social Security Number ____________________

Current Mailing Address: __________________________________ City__________________

State___________________ Zip: __________________ Email: ___________________________

Cell Phone: ______________________ Home Phone: ________________

Employer: ______________________ Work Phone: __________________

EMERGENCY CONTACT

Last Name: _________________________First Name: _________________________________

Relationship to Client: ____

Cell Phone: ____________ Home Phone: _____________ Work Phone: __________________

If there is another biological, adoptive, or legal parent/guardian, please provide their information with a note about their legal rights.

Signature______________________________ Date: ________________________________

Parkside
Psychiatric Hospital & Clinic

OUTPATIENT CONSENT FORM

Patient Label

CONSENT TO PHOTOGRAPH

I authorize one photograph for the purpose of identification during treatment at Parkside. I understand that this photograph becomes a part of the permanent confidential patient record. Prints or negatives of this photograph will not be used without my written consent for any other purpose.

APPROVAL: YES_____ NO_____ INITIAL______

OPPORTUNITY TO EXECUTE AN ADVANCE DIRECTIVE

I have been educated about Advance Directives and I have been informed of my right to formulate an Advance Directive. I have been offered assistance to write an advance directive. I understand that I do not have to have an Advance Directive to receive treatment at this hospital.

APPROVAL: YES_____ NO_____ INITIAL_____

NOTICE OF PRIVACY PRACTICES

I have read the Parkside Privacy Practices. I have been given a copy if I requested one. I have read my patient Rights and Responsibilities have been given to me if I requested.

APPROVAL: YES_____ NO_____ INITIAL_____

____

Signature of patient or legal guardian Date

____

Signature of witness by staff **Date**

PARKSIDE, INC.
Health Screening

Patient Name: ______________________ Patient Number: __________

SSN: __________ Date of Birth: __________ Date of Completion: __________

Person Completing Form: ______________________ Relationship: __________

PRIMARY CARE DOCTOR

Name: ______________________

Address: ______________________

Phone: ______________________

Date of Last Visit: __________ Reason for visit: __________ Date of Last Physical Exam: __________

DO YOU NOW HAVE or HAVE YOU EVER HAD... (If yes, explain)

YES NO PAST Eye problems or need glasses? __________
YES NO PAST Hearing problems? __________
YES NO PAST Speech problems? __________
YES NO PAST Dental problems? __________
YES NO PAST Fainting spells, passing out, or dizzy spells? __________
YES NO PAST Seizures, Epilepsy, convulsive fits? __________
YES NO PAST Inability to move a part of your body? __________
YES NO PAST Bad headaches? __________
YES NO PAST Goiter or thyroid problems? __________
YES NO PAST Pains in your chest? __________
YES NO PAST High blood pressure? __________
YES NO PAST Swelling in hands, feet, or ankles? __________
YES NO PAST Kidney troubles? __________
YES NO PAST Stomach troubles or ulcers? __________
YES NO PAST Diabetes? __________
YES NO PAST Liver disease, or skin or eyes turn yellow? __________
YES NO PAST HIV – AIDS ? __________
YES NO PAST Recent change in appetite or eating habits? __________
YES NO PAST Recent change in bowel habits? __________
YES NO PAST Medical reasons you can not work? Explain: __________
YES NO PAST Other medical problems? Explain: __________
YES NO PAST Have you or any of your family members been exposed to tuberculosis (TB)? __________
YES NO PAST Have you ever had a positive tuberculosis (TB) skin test? If yes, name of medication taken: __________
How long did you take the medication? __________ Date & Location of last chest x-ray: __________
YES NO PAST Have you ever had surgery or other medical procedures? Explain: __________
YES NO Are you currently experiencing pain? If yes, how bad does it feel: (none0 1 2 3 4 5 6 7 8 9 10Extreme)
Describe type of pain and location: __________
Females Only → Are you currently pregnant? ☐ Yes ☐ No Any past trouble with pregnancy? ☐ Yes ☐ No __________

FAMILY MEDICAL HISTORY

Has any member of your biological family ever had any of the following conditions? If yes, explain.

Heart problems? ☐ Yes ☐ No __________ Diabetes? ☐ Yes ☐ No __________
High blood pressure? ☐ Yes ☐ No __________ Cancer? ☐ Yes ☐ No __________

HABITS (average amounts)

Sleep ____ Hours/night		Cigarettes ____ Packs/day		Alcohol ____ Amount/day	
Water ____ Glasses/day		Cigars ____ Per/day		Marijuana ____ Amount/day	
Coffee ____ Cups/day (regular or decaf)		Other tobacco:		Other drugs:	
Tea ____ Glasses/day (regular or decaf)		________ ____ Per/day		________ ____ Amount/day	
Soda ____ Glasses/day (regular or diet)		________ ____ Per/day		________ ____ Amount/day	

MEDICATION HISTORY (all medications, including over-the-counter)

*By mouth, Injection, IV, other means

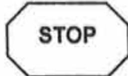
Present/Past	Medication	Strength	*Route Taken	How Often Taken	Start Date	End Date	Reason Taken	Prescribing Doctor
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								
☐ Present ☐ Past								

ALLERGIES

Do you have any allergies? ☐ Yes ☐ No

If yes, please explain: ______________________________

____



DO NOT WRITE BELOW THIS LINE

PHYSICIAN RECOMMENDATION

It is the recommendation of the Parkside Medical Staff that each individual make regular visits to a physician for screenings and physicals. Upon review of the information provided by the client and as documented on this form:

_____ It is recommended that the individual named on this form receive a medical history and physical or other medical treatment prior to commencement / continuation of treatment for psychiatric disorders.
(circle one)

_____ It is **not required** that the individual named on this form receive a medical history and physical or other medical treatment prior to the commencement and/or continuation of treatment for psychiatric disorders.

______________________________ Physician Signature

______________________________ Date

S Form, CP, Form W 150 Revised 01/12/16

Parkside
Psychiatric Hospital & Clinic

FINANCIAL INFORMATION

Patient Name: ______________________ DOB: ______________ SSN: ________________

Medicaid

Policy #: __________________

Annual Household Income: ______________

Total Household Size: ______________

Medicare

Policy#: ____________________

Name on Card: ______________

Primary Insurance Information: *To verify benefits and file claims, all information must be provided below.*

Insurance Company: __________________ Phone: ____________________________

Subscriber Last Name: __________________ First Name: ________________ MI: ______

Subscriber SSN: ______________ DOB: ____________ Relationship to Client: ____________

Policy#: __________________ Group #: _____________ Group Name: ________________

Employer Name: _________________________ Employer Phone #: __________________

Secondary Information (if applicable):

Insurance Company: _____________________ Phone: ____________________________

Subscribed Last Name: __________________ First Name: _________________________

Subscriber's SSN: ___________________ DOB: _____________ Relationship to Client: ________

Policy #: ____________________ Group # _____________ Group Name: _______________

Employer Name: _______________________ Employer Phone #: ______________________

Other Insurance (if applicable):

Insurance Company: __________________ Phone: ____________________________

Subscriber Last Name: __________________ First Name: ________________ MI: ______

Subscriber SSN: ______________ DOB: ____________ Relationship to Client: ____________

Policy#: __________________ Group #: _____________ Group Name: ________________

Employer Name: _________________________ Employer Phone #: __________________

___Self Pay. No Insurance Coverage: Payment due in full at time of service. Self-pay discount applies.

Signature: __________________________ Date: ______________________________

W 68 revised 8/2023