Patient Information					
Patient Last Name	**Patient First, M. Name**	**Social Security #**	**Date of Birth**	Age	Gender
Home Mailing Address:		**City**	**State**	**Zip Code**	
Mobile Phone Number:		Home Phone Number:			
Email Address:					
Marital Status: Single/ Married/ Divorced/ Partnered		Number of Years Together:			
Name of Spouse:		Number of Children:			
Insurance Responsible Party: Only if not your self					
Last Name	First Name	Social Security #	Date of Birth	Phone Number	
Mailing Address:		City	State	Zip Code	

Emergency Contact Information			
Name	**Relationship**	**Primary Phone**	Secondary Phone
Is it okay to contact this person in a **NON-EMERGENCY? Yes or NO**			

Insurance Information		
Primary Insurance Co.	**ID Number:**	Copay:
Secondary Insurance Co.	ID Number:	Copay:

Patient Release		
I certify the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for the purposes of filing and payment of mental health claims. I acknowledge that interest or a fee, at the provider's current rate, may be charge on all balances owing to the provider that are past due. ***I am aware that I will be charged $35 if an appt is not cancelled 24hrs in advance. This will not be covered by my insurance.*** The first missed appt will result in a "warning". Three or more missed appts/year may result in dismissal from this practice.		
Signature of Patient or Legal Guardian	**Print Name**	**Date**

Tony A. Pham, M.D., P.A.

Psychopharmacology & Psychotherapy
1315 St. Joseph Parkway, Suite 1307
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mail@tonyphammd.com

Year 2022 Deductible

Most insurance policies have deductible amounts that must be paid first before the insurance policy would start to pay. We have no way of knowing whether your deductible amounts have been met for this year.

As a courtesy, we will only charge you your regular copay, but ask that you give us your credit card information. We will bill any applicable amounts not covered by insurance to your credit card when we receive your insurance explanation of benefits.

Patient name _____
Card type (Visa, mastercard, etc) _____
Card # _____
Expiration date: _____ CVV: _____

I agree to pay any applicable amounts.

_____ (signature)

Date: _____

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phamtony98@yahoo.com

Consent for Release of Protected Health Information
(Entire Medical Records)

I request my records from (below) be released to Dr. Pham

_____, _____
(Physician, Hospital or Institution) (Address/Phone)

Names of people Dr.Pham/office can disclose information to:

_____, _____
(Individuals or Institutions) (Address/Phone)

I,_____, DOB _____
consent to release of the protected health information that is required to carry out treatment, payment and healthcare operation on my behalf.

I have read the Notice of Privacy Practices (on office wall, or request copy from front desk) and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that Dr. Pham is not required to agree with my requested restrictions. I also understand that once Dr. Pham agrees to my restrictions, I must comply with those.
- I have the right to revoke my consent for the use and disclosure of my protected health information at anytime. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Dr. Pham must immediately comply with my request to revoke consent, except to the extent that some action has already been taken that was based on my original consent.
- Dr. Pham has reserved the right to change our privacy practices at anytime without notification.

Note: Only the patient or parent/guardian may request a release of medical information. Picture ID may be required.

_____ _____
Print Patient's Name **Date of Birth**

_____ _____
Signature of Patient/Guardian **Date**

Name:_____

Patient Questionnaire

1. Describe in 1-5 sentences why you are being referred to our office.

2. Have you been hospitalized before for mental health issues? Yes / No (please circle)
   If so, when was the most recent?

3. Have you used the following substances, either now or in the past?

Alcohol	Yes / No
Cocaine	Yes / No
Marijuana	Yes / No
Heroin	Yes / No
Stimulants	Yes / No
Cigarettes	Yes / No

4. Where were you born?
5. What is/was your occupation?
6. What is your religion (if any)
7. What is your current living situation? Care home / with relatives / house or apartment
   nursing home / no stable residence
8. Do you have children? Yes / No. If so, how many?
9. What is your education level? Some high school / graduated HS / some college
   or college degree / advanced degree
10. Have you had any legal problems or arrests? Yes / No

11. Do you have any medical problems? Diabetes / hypertension / heart problems hepatitis /
    kidney problems / high cholesterol
    Are you pregnant? Yes / No
    Please list any other medical problems:

12. Are you allergic to any medications? If so, which ones.

13. Please list the medicines that you are currently taking.

Name:_____ Date:_____

1. Have you suffered from any of the following symptoms in the past month?

	Not at all	**Several days**	**More than half of the days**	**Nearly everyday**
a. Little interest or pleasure in doing things.	0	1	2	3
b. Feeling down, depressed or hopeless.	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
d. Feeling tired or having little energy.	0	1	2	3
e. Poor apetite or overeating.	0	1	2	3
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
i. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
Add columns:		_____+	_____+	_____
Total (sum of above) =				

	Not at all	**Several days**	**More than half the days**	**Nearly everyday**
a. Anxious mood				
b. Irritability/anger				
c. Hearing voices / hallucinations				
d. Poor concentration				
e. Forgetfulness				

2. Have you used any of the following substances within the past month?

Alcohol:	*Rarely*	*Sometimes*	*Frequently*	*Daily*
Marijuana:	*Rarely*	*Sometimes*	*Frequently*	*Daily*
Cigarettes:	*Rarely*	*Sometimes*	*Frequently*	*Daily*

Other drugs (please list):

3. Have you had trouble at work or at home as a result of your mental health condition? If so, please explain.

4. Have you been diagnosed with any of the following mental health disorders?

- Major depression
- Bipolar disorder
- ADD or ADHD
- OCD (obsessive compulsive disorder)
- Schizophrenia
- Panic disorder
- Alcohol abuse
- Drug abuse

Patient Name: _____ DOB: _____

General Health Questionnaire

Have you suffered from any of the following within the past month? (Please circle all that apply):

Constitutional: fever / night sweats / weight gain / weight loss

Head: blurred vision / fainting / head trauma / headache / seizures

Eyes: diminished vision in (both eyes / right eye / left eye) / double vision / eye pain / infection / itching / visual blurring

Ears/Nose/Throat: dizziness / dryness of mouth / frequent sore throats / hearing difficulties / hearing loss / hoarseness / infected gums / runny nose / loss of smell / nasal obstruction / ringing in the ears / sinus infection / sore throat

Respiratory: chills / cough / difficulty breathing / exertional dyspnes / fever / hemoptysis / non-exertional dyspnea / pleuritic pain / rib pain / shortness of breath

Cardiovascular: chest pain / dizziness / lightheadedness / palpitations / tachycardia

Gastrointestinal: abdominal pain / bloating / constipation / diarrhea / dyspepsia / fatty food intolerance / heartburn / nausea / vomiting

Genitourinary: abnormal menses / blood in urine / cysts / difficulty voiding / dysuria / foamy urine / frequency / hematuria / hesitancy / incontinence / painful urination / urinary tract infection

Musculoskeletal: arthritis / back pain / decreased range of motion / joint pain / joint swelling

Skin: dry skin / hair loss / jaundice / rashes / discoloration

Neurological: dizziness / headaches / loss of consciousness / memory loss / migraines / motor disorder / neuropathy / numbness / recent seizure / stroke / weakness

Endocrine: changes in hair texture / cold sensation / excessive sweat / excessive thirst / goiter

Hematologic: anemia / bleeding disorder / bruising / leukemia / night sweats

Allergy and Immunology: hives / seasonal allergies

Patient/Guardian Signature: _____ Date: _____

Name_____ Date_____

Family History

The U.S. Government has mandated that detailed family history be recorded in your chart. Please help us to do this by providing information below.

1. Did your family have any of the following illnesses?

    a. **Mother**: Age_____□Living □Deceased
    (If deceased, provide age and year of death→age_____/year_____)
    →Circle the following that applies: none/depression/schizophrenia/bipolar disorder/anxiety/dementia/ heart disease/cancer, which?_____)/
    hypertension/diabetes/ asthma/alcohol addiction/drug addiction

    b. **Father**: Age_____□Living □Deceased
    (If deceased, provide age and year of death→age_____/year_____)
    →Circle the following that applies: none/depression/schizophrenia/bipolar disorder/anxiety/dementia/ heart disease/cancer, which?_____)/
    hypertension/diabetes/ asthma/alcohol addiction/drug addiction

    c. **Circle one**→Brother/Sister: Age_____□Living □Deceased
    (If deceased, provide age and year of death→age_____/year_____)
    →Circle the following that applies: none/depression/schizophrenia/bipolar disorder/anxiety/dementia/ heart disease/cancer, which?_____)/
    hypertension/diabetes/ asthma/alcohol addiction/drug addiction

    d. **Circle one**→Brother/Sister: Age_____□Living □Deceased
    (If deceased, provide age and year of death→age_____/year_____)
    →Circle the following that applies: none/depression/schizophrenia/bipolar disorder/anxiety/dementia/ heart disease/cancer, which?_____)/
    hypertension/diabetes/ asthma/alcohol addiction/drug addiction

2. Any other relevant family history? (Grandmother maternal, grandfather maternal, grandmother paternal, grandfather paternal etc.) Please make note below.

Pharmacy Form

Your Information

First name_____

Last Name_____

Pharmacy Information

Pharmacy Name: _____

Phone: _____

Fax: _____

Street Address_____

City/State/Zip_____

Primary Doctor Info:

Name:_____

Phone:_____