

Katie Danielle Wade, MSN, APRN, PMHNP-BC
7161 Lee Highway, Suite 400
Chattanooga, Tennessee 37421
Office: 423-708-8670
Fax: 423-708-8671

ADULT INFORMATION FORM

Identifying Information
This Form is Confidential

Today's date: _____

Your name: _____
Last First Middle Initial

Date of birth: _____ Age: _____ Social Security #: _____

Gender & Sexual Identity

Male Female Transgender Other _____
 Heterosexual Lesbian Gay Bisexual Asexual In Question Other

Racial/Ethnic Identity:

African/African-American/Black Latino/Latino-American Bi-Racial/Multi-Racial
 American Indian/Alaska Native Middle Eastern/Middle Eastern-American
 Asian/Asian-American/Asian Pacific Islander White/European-American Not listed

Home address: _____

City: _____ State: _____ Zip: _____

Email: _____

Cell Phone: _____ Work Phone: _____

Can we leave a message at the numbers listed above? YES or NO

Referred by: _____ telephone number: _____

Your signature indicates that we can communicate with the referral source:

(Parent/Guardian Signature): _____

Patient's PCP: _____ Office number _____

Your signature indicates that we can communicate with your PCP as needed :

(Parent/Guardian Signature): _____

Person(s) to notify in case of any emergency:

Name _____ cell number _____

Name _____ cell number _____

I will only contact this person if I believe it is a life or death emergency. Please provide your signature to indicate that I may do so: (Your Signature): _____

Pharmacy Info:

Pharmacy Name: _____ Pharmacy Address: _____

Pharmacy Phone: _____ Pharmacy Fax: _____

Employer: _____
Address of Employer: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE INFORMATION:

Name of Insured Person:

Last First Middle Initial
Insured's relationship to patient _____ Insured's DOB: _____

Insurance Company: _____ Insurance ID number _____

Insurance Group number _____ Insured's SSN: _____

Secondary Insurance

Name of Insured Person:

Last First Middle Initial
Insured's relationship to patient _____ Insured's DOB: _____

Insurance Company: _____ Insurance ID number _____

Insurance Group number _____ Insured's SSN: _____

Tertiary Insurance

Name of Insured Person:

Last First Middle Initial
Insured's relationship to patient _____ Insured's DOB: _____

Insurance Company: _____ Insurance ID number _____

Insurance Group number _____ Insured's SSN: _____

Please briefly describe your presenting concern(s): _____

PAST MEDICAL HISTORY:

Height _____ Weight (if applicable) _____ Age _____

Previous medical hospitalizations (Approximate dates and reasons):

Hospital	Date:	Reason:

Place an X by past surgical procedures (Approximate dates and reasons):

Procedure:	Date:	Procedure:	Date:
<input type="checkbox"/> Anesthetic Complications		<input type="checkbox"/> Heart Surgery	
<input type="checkbox"/> Appendectomy		<input type="checkbox"/> Hemorrhoidectomy	
<input type="checkbox"/> Breast Surgery		<input type="checkbox"/> Hernia Repair	
<input type="checkbox"/> Bowel Resection		<input type="checkbox"/> Hip Replacement	
<input type="checkbox"/> Bladder Repair		<input type="checkbox"/> Hysterectomy	
<input type="checkbox"/> Cancer removal		<input type="checkbox"/> Kidney Removal	
<input type="checkbox"/> Cardiac Pacemaker		<input type="checkbox"/> PE Tubes	
<input type="checkbox"/> Carpal Tunnel		<input type="checkbox"/> Splenectomy	
<input type="checkbox"/> Cesarean Delivery		<input type="checkbox"/> Thyroidectomy	
<input type="checkbox"/> Dialysis		<input type="checkbox"/> Tonsillectomy	
<input type="checkbox"/> Gall Bladder Removal		<input type="checkbox"/> Tubal Ligation	
<input type="checkbox"/> Other		<input type="checkbox"/> Wisdom Teeth Ext.	
		<input type="checkbox"/> Vasectomy	
		<input type="checkbox"/> Other	

Are you allergic to any medications? If yes, please list with reaction:

Medication/Food Allergy:	Date (age):	Reaction:

Place an X by any significant medical problems, symptoms, or illnesses:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Dementia Alzheimer	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Arthritis/Joint Dz	<input type="checkbox"/> Dementia Parkinson	<input type="checkbox"/> HIV	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> Insomnia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Bladder Issues	<input type="checkbox"/> DVT/Blood Clot	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> UC/Crohns Dz
<input type="checkbox"/> Bowel Issues	<input type="checkbox"/> Female Issues	<input type="checkbox"/> Narcolepsy	
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Pain (Chronic)	<input type="checkbox"/> Other
<input type="checkbox"/> Cancer	<input type="checkbox"/> GERD	<input type="checkbox"/> Polycystic ovaries	
<input type="checkbox"/> COPD/Lung Dz	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other
<input type="checkbox"/> CVA/Stroke	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Skin Disorders	

Current Medications: (NON PSYCHIATRIC)

Medication:	Dose:	Purpose:	Prescriber:

PAST PSYCHIATRIC HISTORY:

Have you ever talked with a psychiatrist, psychologist, or other mental health professional? YES NO
 (Please list approximate dates and reasons): _____

Have you ever thought about committing suicide? Please describe:

Have you ever tried to commit suicide? Please describe:

Previous psychiatric hospitalizations (Approximate dates and reasons):

Hospital:	Date:	Reason:	Treatment:

Place an X by any significant psychiatric problems for which you have been treated:

<input type="checkbox"/> ADHD inattentive	<input type="checkbox"/> Autism	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Panic Disorder with agoraphobia
<input type="checkbox"/> ADHD hyperactive	<input type="checkbox"/> Bipolar Type I Depression	<input type="checkbox"/> Generalized Anxiety	<input type="checkbox"/> Panic Disorder without Agoraphobia
<input type="checkbox"/> ADHD mixed type	<input type="checkbox"/> Bipolar Type I Mania	<input type="checkbox"/> Impulse Control d/o	<input type="checkbox"/> Psychosis <input type="checkbox"/> PTSD
<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> Bipolar Type I Mixed	<input type="checkbox"/> Kleptomania	<input type="checkbox"/> Reactive Attachment Disorder
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Bipolar Type II	<input type="checkbox"/> Marijuana abuse	<input type="checkbox"/> Schizoaffective
<input type="checkbox"/> Asperger's	<input type="checkbox"/> Borderline Personality	<input type="checkbox"/> OCD	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Other	<input type="checkbox"/> Depression	<input type="checkbox"/> ODD	<input type="checkbox"/> Substance Abuse <input type="checkbox"/> Trichotillomania

Current Psychiatric Medications

Medication:	Dose:	Reaction or Reason Discontinued	Prescriber:

Previous Psychiatric Medications:

Medication:	Dose:	How Long:	Prescriber:

SOCIAL HISTORY:

Do you smoke or use tobacco? YES NO If YES, how much per day? _____

Do you consume caffeine? YES NO If YES, how much per day? _____

Do you drink alcohol? YES NO If YES, how much per day/week/month/year? _____

Do you use any non-prescription drugs? YES NO

Have any of your friends or family members voiced concern about your substance use? YES or NO

Have you ever been in trouble or in risky situations because of your substance use? YES or NO

If you answered yes to anything of the substance abuse questions, please place an "X"

___ Adderall	___ Cocaine derivatives	___ Marijuana	Others (please list):
___ Air Duster	___ Crack	___ Mushrooms	
___ Alcohol	___ Inhalants	___ PCP	
___ Barbiturates	___ Ketamine	___ Triple CCCs	
___ Bath Salts	___ LSD	___ Valium, Xanax, Ativan, Klonopin	

LEGAL:

Have you ever been arrested? If yes please list

Are you currently on probation or ever been on probation? If yes please list

RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:

Currently in Relationship? ___ How Long? ___ Relationship Satisfaction: ^{POOR} 1 2 3 4 5 6 7 ^{EXCELLENT}

Married/Life Partnered? ___ How Long? ___ Previously Married/Life Partnered? YES NO
If so, length of previous marriages/committed partnerships _____

Do you have Children? ___ If YES, how many and what are their ages: _____

Describe any problems any of your children are having: _____

List the names and ages of those living in your household: _____

Please briefly describe any history of abuse, neglect and/or trauma: _____

Current level of satisfaction with your friends and social support: ^{POOR} 1 2 3 4 5 6 7 ^{EXCELLENT}

Please briefly describe your coping mechanisms and self-care: _____

Is spirituality important in your life and if so please explain: _____

Briefly describe your diet and exercise patterns: _____

EDUCATION & CAREER

High School/GED ___ College Degree ___ Graduate Degree(or Higher) ___ Vocational Degree ___

What is your current employment? _____

Please place an “x” in the now or past box if the problem listed applies to the patient:

Problems with	Now	Past	Problems with	Now	Past
Anxiety			Makes careless mistakes		
Depression			Fidgets frequently		
Anger/Temper			Impulsive		
Panic			Waiting their turn		
Fears			Completing tasks		
Irritability			Easily distracted		
Concentration			Hyperactivity		
Worries			Alcohol abuse		
Talking with others			Drug use		
Separation anxiety			Problems falling asleep		
Tantrums			Problems staying asleep		
Parents Divorced			Unexplained weight loss		
Cries easily			Unexplained weight gain		
Problems with friends			Frequent upset stomach		
Problems in school			Frequent headaches		
Fear of strangers			Diarrhea		
Afraid of the dark			Excess sweating		
Sexually acting out			Shortness of breath		
History of child abuse			Dizziness		
History of sexual abuse			Fainting		
Thoughts of hurting others			Nausea		
Thoughts of hurting self			Constipation		
Nightmares			Chest pain		

FAMILY HISTORY: Please mark an "X" in the box that applies to family members.

Disorder	mother	father	maternal grandma	maternal grandpa	paternal grandma	paternal grandpa	uncle	aunt	sister	brother
Adhd										
Anxiety										
Aspergers										
Autism										
Bipolar										
Depression										
Psychiatric Hospitalization										
OCD										
Panic Attacks										
PTSD										
Schizophrenia										
Substance Abuse										
Suicide attempt										
Suicide Completion										

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Authorization For Treatment, Payment and Healthcare Operations:

I authorize Danielle Wade, to release to my insurance company, managed care organization, state agency, Health Care Financing Administration, Third Party Administration any information needed to process my claims and or determine benefits payable for related services.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges at the time of service. I understand that unless otherwise restricted by a contractual agreement with selected insurance plans/third party payers, the entirety of the charges incurred will be transferred to the the guarantor's responsibility if the payment is not received from the insurance company within 60 days. I understand that I will be bound by any conditions of this agreement regarding guarantor/patient responsibility charges. I understand that failure to meet my financial responsibility in a timely manner may result in my account being turned over to a collections agency. I understand that payment is due at the scheduled appointment.

There is a \$30 fee for all returned checks. If two returned checks are received, Danielle Wade reserves the right to request future payments be made in cash or credit card.

I give consent for evaluation and treatment by Danielle Wade.

I have read, understand and agree to the above policies.

Print Patient/Guarantor Name

Patient/Guarantor Signature (must be at least 18 years old)

Date

Witness Signature

Date

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Missed Appointment and Late Cancellation Policy

Danielle Wade whenever possible, will call you to remind you of your appointment but, you are responsible for attending your scheduled appointment. A \$50 fee will be added to the patient's account if a patient does not attend their appointment or if they cancel their appointment within 24 hours of the scheduled appointment time. This fee is not covered by insurance and must be paid at the next appointment.

***Please initial if you would or would not like to receive notification about your appointment.**

_____ Yes, I want Danielle Wade to text me at this number to remind me of a scheduled appointment. Telephone number _____. An email is required to set up text reminder services. Email: _____

_____ No, I DO NOT want Danielle Wade to attempt to contact me to remind me of my scheduled appointment time.

After Hour Calls Policy

Calls made to the provider after hours are subject to a \$25 fee due at the next scheduled appointment.

Paperwork Policy

There is a \$35 fee for any paperwork (FMLA paperwork, Disability forms, Letters, School forms etc.) completed by a provider.

Medication Refill Policy

Danielle Wade requires a 72 hour notice for medication refill request to be processed. When requesting a refill patient/guardian must provide the following information: name of medication, dose, when medication is taken, pharmacy name and telephone number. Request for refills may be left on the refill line, please keep in mind calls received after 3pm daily will not be returned until the next business day.

I have read, understand and agree to the policies listed above.

Print Patient/Guarantor Name

Patient/Guarantor Signature (must be at least 18 years old)

Date

Staff Signature

Date

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Acknowledgement of Receipt of Patient Notification of Privacy Practices

I, _____ have been presented with a copy of
Katie Danielle Wade, MSN, APRN, PMHNP-BC, Patient Notification of Privacy Practices,
detailing how my information may be used and disclosed as permitted under federal and state
law and I understand the contents of the Notification. By law, Katie Danielle Wade, MSN, APRN,
PMHNP-BC, is required to obtain your signature indicating that you have received this
document. Your signature below does not surrender any rights or confidentiality. Any updates to
this policy will be posted on our website or in our waiting room for your review.

Patient Name _____ DOB _____

Print Patient/Guarantor Name _____ Date _____

Patient/Guarantor Signature (must be at least 18 years old) _____ Date _____

For Internal Use

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date the notice was presented to the patient and sign below.

Presented on (date) _____

By: (name and title) _____

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CONSENT FOR RELEASE OF MEDICAL INFORMATION:

I, _____ grant permission for the person(s) listed below to have access and all of my information that pertains to my care from the physicians or providers of this group. This includes but is not limited to, appointment time, lab results, my physician's plans for health care, etc. I agree to notify in writing, if there are any changes in the person(s) authorized.

Patient Name: _____ DOB _____ / _____ / _____

Signature (patient or legal guardian): _____

Date: _____ / _____ / _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

