MARIETTA PSYCHIATRY ASSOCIATES PC PLLC
3298 S 3RD STREET,
MEMPHIS, TN 38109
Phone: (901) 306-4122 Fax: (901) 306-4123

PATIENT REGISTRATION

Patient

First Name: _____________________ Last Name: __________________ Middle Initial: _____

Preferred Name if any: __________________ Date of Birth: ____________________

Biological Gender: Male/Female Preferred Gender if any: ___________________

Street Address: _______________________ City: _________________ State: ___ Zip: ________

Home Phone: ______________________ Preferred Language: _________________

Race: __Caucasian __Black or African American__ Asian __ Native American/ American Indian __Alaskan Native/ Native Hawaiian __ Other Pacific Islander __Other__ Decline to answer

Ethnicity: __Hispanic or Latino __ Non-Hispanic or non-Latino__ Decline to answer

Parent/Legal Guardian

First Name: _____________________ Last Name: __________________ Middle Initial: _____

Preferred Name or Other Names used if any: __________________

Date of Birth: ____________________

Relationship to Patient: __ Mother __ Father __Stepmother__Stepfather__Custodial relative
__ Other

Biological Gender: Male/Female   Preferred Gender if any: _________

Race: __Caucasian __Black or African American__ Asian __ Native American/ American Indian __Alaskan Native/ Native Hawaiian __ Other Pacific Islander __Other__ Decline to answer

Ethnicity: __Hispanic or Latino __ Non-Hispanic or non-Latino__ Decline to answer

Home Address: ________________   City: ___________ State: ___ Zip:________

Home Phone:_____________ Cell Phone:_______________ Email: ________________

Employer: _______________

Work Address: ______________________ City: ________________ State: ___ Zip: ________

Work Phone: _______________

Social Security: ________________ Driver's License number: ______________

Preferred Language: ________________ Preferred method of Contact: __Home phone __Cell phone __ Email __patient portal

Responsible Party (Guarantor):___ Yes ___ No

Parent/Legal Guardian

First Name: ____________________   Last Name: _________________   Middle Initial: _____

Preferred Name or Other Names Used if any: _________________

Date of Birth: ___________________

Relationship to Patient: __ Mother __ Father __Stepmother__Stepfather__Custodial relative
__ Other

Biological Gender: Male/Female   Preferred Gender if any: _________________

Race: __Caucasian __Black or African American__ Asian __ Native American/

American Indian __Alaskan Native/ Native Hawaiian __ Other Pacific Islander
__Other__ Decline to answer

Ethnicity: __Hispanic or Latino __ Non-Hispanic or non-Latino__ Decline to answer

Home Address: ________________________ City: _________________ State: ___

Zip:_________

Home Phone:______________ Cell Phone:________________ Email:
____

Employer: ________________

Work Address: ________________________ City: _________________ State: ___
Zip:_________

Work Phone:________________

Social Security: _________________ Driver's License number: _______________

Preferred Language: _________________

Preferred method of Contact: __Home phone __Cell phone __Email __ Patient Portal

Responsible Party (Guarantor):___ Yes ___ No

Responsible Party/ Guarantor if not a Parent or Legal Guardian

First Name: ______________________ Last Name: __________________ Middle
Initial: _____

Other Names Used if any: __________________

Date of Birth: ____________________ Relationship to Patient: __________________

Home Address: ________________________ City: _________________ State: ___

Zip: _________

Home Phone: ______________ Cell Phone: ________________ Email:
____

Work Phone: ________________

Social Security: _________________ Driver's License number: _______________

Preferred Language: ________________

Preferred method of Contact: __Home phone __Cell phone __ Work phone __Email

Emergency Contact

First Name: ____________________ Last Name: _________________ Middle Initial: _____

Other Names Used if any: _________________

Date of Birth: ___________________ Relationship to Patient: _________________

Home Address: ______________________ City: ________________ State: ___

Zip: ________

Home Phone: _____________ Cell Phone: _______________ Email: ________________

Work Phone: _______________

Social Security: ________________ Driver's License number: ______________

Preferred Language: ________________

Preferred method of Contact: __Home phone __Cell phone __ Work phone __Email

Insurance Information

Primary Insurance Name: ____________________

Member ID Number: __________________ Group Number: _________________

Rx Bin Number: ___________________

Name of Policy Holder: __________________________________

Secondary Insurance Name: ____________________

Member ID Number: __________________ Group Number: _________________

Rx Bin Number: ___________________

Name of Policy Holder: ________________________________

Credit Card Information

__ Master Card __ Visa __ Amex

Name on Credit/Debit Card: _______________________

Credit/ Debit Card number: ________________________

Expiration Date: ______________ CVV: ______________

Pharmacy Information

Name of Preferred Pharmacy: ________________________ Phone: ________________

Address: ______________ City: __________________ State: _____Zip: ____________

Name of Secondary Pharmacy: ________________________Phone: ________________

Address: ______________ City: __________________ State: ____Zip: ____________

Preferences

Any religious or cultural preferences for receiving medical care that we should be aware of? ________________________________
Any preferred method of learning and receiving information regarding medical care? ____

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physician and staff of MARIETTA PSYCHIATRY ASSOCIATES PC to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained herein are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage, excluding only

authorized services provided under a valid prepaid HMO contract. I furthermore agree to pay legal interest, collection expenses, and attorneys' fees incurred to collect any amount I may owe. I also hereby authorize MARIETTA PSYCHIATRY ASSOCIATES PC to release information requested by insurance company and/or its representatives. I fully understand this agreement, and my consent will remain in effect until cancelled by me in writing.

Signature of Patient/Parent/Legal Guardian: ___________________________

Name of Patient/Parent/Legal Guardian: _____________________ (Please Print)

Relationship to Patient: ___________________ Date: _________________

Medical History

Check all that the patient has experienced and year and month of onset

__ Allergies Mo/YR
    __ Food allergies
    __ Animal allergies
    __Seasonal allergies
    __Medication allergy
    __Insect allergies
    __Other allergies
__ Anemia ________
__ Asthma ________
__ Autoimmune diseases ________
__Birth difficulties ________
__Blood disorders
__Bone disease
__Cancer
__Celiac disease
__Cerebral Palsy
__Constipation
__Cystic fibrosis
__Eczema
__Endocrine or hormonal problems
__Eosinophilic Esophagitis

__Food Intolerance
__Gastroesophageal Reflux
__Genetic disorders
__Growth issues
__ Heart disease
__ Hearing problems, or wears hearing aids
__ Hernia
__ Immune deficiency
__Joint pain
__Kidney disease
__Migraine Headaches
__ Prematurity
__Scoliosis
__Seizure
__Sleep disturbances
__Stroke
__Thyroid problems
__Vision problems, or wears eye glasses
__Chronic Vomiting
__Weight issues

Developmental and Psychiatric History
__ADHD
__Anxiety
__Autism
__Aggression/Irritability
__Conduct disorder
__Depression
__Developmental Delays
__Eating disorder
__Feeding difficulties
__Learning disorders
__Oppositional Defiant Disorder
__Self harm or cutting
__Substance abuse
__Suicide attempt or ideation
__Tourette's Syndrome

Services and Therapy Interventions Received
__Individualized Education Plan (IEP) in school

__504 Plan in school
__Early Intervention Services in early childhood
__Individualized Family Service Plan (IFSP)
__Speech therapy
__Occupational therapy
__Physical therapy
__Psychotherapy
__Applied Behavioral Analysis (ABA)
__Respite Care

Surgeries
__Circumcision (if applicable)
__Adenoidectomy
__Tonsillectomy
__Appendectomy
__Ear surgery
__Bowel resection
__Heart surgery
__Hernia repair
__Surgery for fractures
__Other surgery, please specify _________________

Please list hospitalizations with reason for hospitalization, and admission and discharge dates:

Reason for hospitalization	Admission date	Discharge date
______________________	_____________	_____________
______________________	_____________	_____________
______________________	_____________	_____________
______________________	_____________	_____________

Social History

Ethnicity: __Hispanic or Latino __ Non-Hispanic or non-Latino

Parents' Relationship: __Married __Divorced __Widowed __Single __Separated

Patient resides with:
Primary __Mother __ Father __ Both Parents __ Other
Secondary __ Mother __ Father __ Both Parents __ Other __ Not Applicable

Number of brothers who live in the home: _________________
Number of sisters who live in the home: _____________________
Number of siblings who no longer live at home: __________________

Childcare: __ Mother __ Father __ Grandparent/s __ Nanny __ Daycare __ Other

Tobacco Exposure __ Yes __ No Smokers at Home __ Yes __ No

Pets __ Yes __ No; If yes, please specify: ________________________________

International travel to: 1)_____________________ Dates: From________to________
2)_____________________ Dates:
From________to________
3)_____________________ Dates:
From________to________

Medication History

Name	Strength	Form	# of times/day
For example			
Amoxicillin	*250 mg*	*chewable*	*three times a day*
1)__________	_______	________	_______________
2)__________	_______	________	_______________
3)__________	_______	________	_______________
4)__________	_______	________	_______________
5)__________	_______	________	_______________
6)__________	_______	________	_______________
7)__________	_______	________	_______________
8)__________	_______	________	_______________
9)__________	_______	________	_______________
10)__________	_______	________	_______________

Medication Allergy

Medication	Reaction
1) _____________	____
2) _____________	____
3) _____________	____
4) _____________	____
5) _____________	____
6) _____________	____

Family history

Mother Father Brother Sister Grandmother
Grandfather
Allergies
Autoimmune disease
Arthritis

Asthma
Blood disorder
Clotting disorder
Cancer
Celiac disease
Constipation
Cystic fibrosis
Diabetes
Eczema/ skin problems
Food intolerance
Gastroesophageal reflux
Genetic disorders
Heart disease
Hearing impairment
Hypertension
Immune deficiency
Kidney disease
Migraine headache
Seizure
Stroke
Sleep disturbances
Thyroid problems
Vision problems
Mental illnesses
- Suspected or known ADHD
- Suspected or known autism
- Anxiety
- Bipolar disorder
- Depression
- Suicidal attempt
- Eating disorder
- Substance abuse