PATIENT REGISTRATION FORM

TODAY'S DATE: ______________________________

PATIENT INFORMATION/DEMOGRAPHICS:

Full Legal Name (First) (Middle) (Last):	Nickname:

Address: (Number, street, apt.#): ____

City: _________________________________ **State:** _____ **Zip:** __________

Mobile phone#: ___________________________ **Home phone#:** ____________________

Email address: _______________________________________

Date of birth: ______________________ **Age:** ____**Y** Height: _______ Weight: _______

Gender identity: (circle one): **Male** **Female** **Other**

Specify Race:

- ☐ Black or African American
- ☐ White/Caucasian
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or other Pacific Islander
- ☐ Patient declined to specify

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or non-Latino
- ☐ Patient declined to specify

First Language: _________________ Second Language: ______________________

Marital status: **(circle one)**: **Single** **Married** **Divorced** **Separated**

Name of spouse: _________________________________ Spouse's phone number: _________________

Spouse's address if different from patient's: ____

Patient Employment: (if applicable):

Employer:______________________________ **Position/occupation:** _________________________

Employer's address: ____

INSURANCE INFORMATION:

Primary Insurance Company Name: ____

Member ID/Certificate No.: __________________________ Group No.: __________________________

Subscriber Name: _______________________________ Subscriber DOB: _______________________

Claims Address: ____

Secondary Insurance Company Name: ____

Member ID/Certificate No.: __________________________ Group No.: ___________________________

Subscriber's Name: _______________________________ Subscriber's DOB: _____________________

Claims Address: ____

*******INFORMATION FOR THE PATIENT:********

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health care plans must present their insurance ID card to the admininstrative staff after completing this form. Some contract health plans (HM0s, PPOs, IPAs, etc.) require a copayment at the time of service. Most contract health care plans require that the claim be submitted by our office.
3. If you have any questions we will, of course, be happy to assist you.

EMERGENCY CONTACT INFORMATION:

Person to Notify in case of Emergency: ____

Relationship to the patient: ___________________ Phone#: ________________________

Emergency contact address: ____

City/State/Zip code: ____

Medical Health/Psychiatric History Questionnaire

Primary Care Provider (current PCP):

Name: ____________________________________ Phone#: ______________________________

Address: ____

Other Medical Provider:

Name: ____________________________ Phone#: _______________ Specialty: ___________________

Address: ____

Other Medical Provider:

Name: ____________________________ Phone#: _______________ Specialty: ___________________

Address: ____

Psychiatrist/Psychiatric APRN: (current)

Name: ____________________________________ Phone#: ______________________________

City/State: ________________________________ Date last seen: ___________________________

Psychiatrist/Psychiatric APRN: (past)

Name: ____________________________________ Phone#: ______________________________

City/State: ________________________________ Date last seen: ___________________________

Metamorphosis Psyche, LLC
6101 W. Atlantic Blvd., Suite 202, Margate, FL 33063
Tel: (954) 906-4106 / Fax: (954) 906-4029

Therapist(s): (current)

Name: ______________________________________ Phone#: _____________________________

City/State: ___________________________________ Date last seen: _________________________

Therapist(s): (past):

Name: ____________________________________ Phone#: ______________________________

City/State: __________________________________ Date last seen: __________________________

CONCERNS you would like to discuss with the Psychiatric Provider:

____

____

List all **CURRENT PRESCRIPTION MEDICINES** (include dosage, reason you take it, who prescribed it):

____

____

____

List all **OVER-THE-COUNTER MEDICINES**, vitamins, and food supplements that you take:

____

____

ALLERGIES/REACTIONS (mild, moderate, severe):

____

____

____

____

SENSITIVITIES:

____

____

____

____

Do you use an **EPI pen**? **Yes** **No**

List SURGERIES/PROCEDURES: YEAR: Facility incl. City & State:

_________________________________ ______ ____________________________________

_________________________________ ______ ____________________________________

_________________________________ ______ ____________________________________

_________________________________ ______ ____________________________________

Have you had (circle all that apply):

Bleeding problems	Migraines	Hepatitis	Mono	Ulcers
Tuberculosis	Blood clots	Head injury	Drug Addiction	Gallstones
Psoriasis	STDs	Seizures	Memory Trouble	Arthritis
Alcoholism	Heart murmur	Rheumatic Fever	Polio	Shingles
Hearing Trouble	Depression	Mental Illness	Gout	Hemorrhoids
Vision Trouble	COVID-19	Other		

Patient's Current & Past Medical Problems and/or Procedures (If not listed above):

____

____

Have you ever been hospitalized for psychiatric reasons? YES or NO

If yes, name of facility and date(s): ____

____

WOMEN ONLY:

Age at first period _____ Date of last Normal period ___________ No. of pregnancies: ______

No. of live births: ______ Birth control Method ____________

Metamorphosis Psyche, LLC
6101 W. Atlantic Blvd., Suite 202, Margate, FL 33063
Tel: (954) 906-4106 / Fax: (954) 906-4029

Date of last Pap ____________ Done where: ____

Date of last mammogram ______________ Done where: _____________________________________

Do you have (circle all that apply):

Irregular periods	Bad menstrual cramps	Heavy periods	Pelvic pain	Infertility
Hot flashes	Vaginal discharge	Vaginal dryness	Vaginal odor	Vaginal itching
PMS	Breast problems	Abnormal mammograms	Abnormal PAP smear	Fibroids/cysts

ALL CLIENTS:

No. of children:_____

FAMILY HISTORY: Who in your **family** has/had (circle); if cause of death write age of death:

Heart Disease: ____________________________ _____ Diabetes: ______________________ ______

High Blood Pressure: ______________________ ______ Cancer: ________________________ _____

Thyroid disease: __________________________ ______ Glaucoma: _____________________ ______

Genetic disorder: __________________________ ____ Arthritis: _______________________ ______

Stomach problems: ________________________ _____ Alcoholism: _____________________ ______

Mental Illness: ____________________________ _____ Allergies: _______________________ ______

Additional Family Psychiatric Conditions: ____

List any other diseases that run in your family and specify your relationship to each family member listed:

____

____

SOCIAL HISTORY:

Highest Education Level Completed: ____

Do you currently EXERCISE? ______ How much? __________hrs./wk.

Current SMOKER: _____ **or** EX-SMOKER: _____

How much? _____ packs/day and # of years ______ Year you QUIT smoking: ________

Currently DRINK alcohol? _______ **or** EX-DRINKER: _______

How many? ______drinks/per week No. of years drinking: _____ Year you QUIT drinking? ______

Currently attending AA? _____ Previously attended AA? ______ Last AA meeting: __________

Do you *currently* use **(circle)**: **Caffeine** **Artificial sweeteners** **Chewing tobacco** **Diet pills**

Did you use in the *past*: **(circle)**: **Caffeine** **Artificial sweeteners** **Chewing tobacco** **Diet pills**

Are you CURRENTLY using/abusing the following: (Circle all that apply)

Marijuana/cannabis	Cocaine	Crystal Meth	Stimulants	Heroin
Opiates	Hallucinogens	LSD	Benzos	Steroids

In the PAST, have you abused/misused the following: (Circle all that apply)

Marijuana/cannabis	Cocaine	Crystal Meth	Stimulants	Heroin
Opiates	Hallucinogens	LSD	Benzos	Steroids

Other:____

How did you hear about Metamorphosis Psyche: ___________________________________

Revised: (07/2023)