Miles Frank, M.D., PLC

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Charlottesville, VA 22911
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Patient Registration

Patient Information

Name: ______________________ Nickname: ______________________

Gender: ______ Age: ______ Date of Birth: ______________________

Address: ______________________ Home Phone: ______________________

______________________ Cell Phone: ______________________

______________________ Work Phone: ______________________

Social Security No.: ______________________ Email: ______________________

Employer: ______________________ Occupation: ______________________

If patient is a minor, please complete:

Name of Parent/Guardian: ______________________ DOB: ______________________

Address: ______________________ Relationship to child: ______________________

______________________ Home Phone: ______________________

______________________ Cell Phone: ______________________

Employer: ______________________ Work Phone: ______________________

Occupation: ______________________

Name of Parent/Guardian: ______________________ DOB: ______________________

Address: ______________________ Relationship to child: ______________________

______________________ Home Phone: ______________________

______________________ Cell Phone: ______________________

Employer: ______________________ Work Phone: ______________________

Occupation: ______________________

Marital Status of Parents: ______________________ With whom does the child live? ______________________

Who else lives in the home?

Name	Age	Relationship	Occupation

(Use the back of this page for more people)

Financial Information

Who is responsible for payment? ________________________________

Method of Payment: Self-Pay _X_

Social Security No. of Responsible Party: ____________ Relationship to patient: ____________

____ __________________
Signature of Patient or Parent/Guardian of Minor Date

Patient Questionnaire

1. Why are you seeking services? ____

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2. Have you (or your child) ever received counseling services before? If so, where and with whom? ____

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3. Have you (or your child) ever been on medication for a mental health problem? If so, what were you prescribed? By Whom? How long did you take the medication? ____________________

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4. Have you (or your child) ever been hospitalized for a mental health problem? ______________

5. Have others in your family experienced mental health problems?

Medical History

Primary Care Physician:

Address/Phone No.:

1. Do you (or your child) have any current medical problems for which you are receiving treatment?

2. Do you (or your child) have any chronic medical problems for which you are receiving on-going treatment?

Current medications/dosages:

3. Have you (or your child) ever lost consciousness, sustained a head injury, had a seizure, undergone an operation? If so, what was the issue? When did it happen? How did it resolve?

4. Do you (or your child) smoke? Use/abuse alcohol or drugs?

5. For Children: Did your child meet his/her developmental milestones within expected timeframes? Were there issues during the pregnancy or immediately after the birth? ___________

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Personal History

Education:

For Adults: Highest degree/grade completed? ______________________

School: ____

For Children: Current School? ____

Grade: __________ Teacher: ______________________________________

Has your child ever been evaluated for learning or behavioral difficulties by the school? If yes, when? What was the outcome? ____

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Has your child ever received special education? Has your child ever repeated a grade? If yes, when?____

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____

Spiritual Life:

How important is spirituality/religion in your life? ____Very ____Somewhat ____ Not important

Denomination _____________________________ Church/Synagogue ________________________

Other information:

Have you (or your child) ever been involved with the police? Social services? Court system? If so, under what circumstances? How did it resolve? _______________________________________

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What stressors are you (or your child) facing now or have faced within the last year (e.g., divorce, death of family member, bullying, etc.)? ____

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Is there any other information you need think it is important to be shared? ____________________

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Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have been given the opportunity to receive, review, and discuss the Notice of Privacy Practices for the mental health practice of *Miles Frank, M.D., PLC*.

____ ________________
Signature of Patient or Parent/Guardian of Minor Date

_______________________ ____
Relationship to patient Name of minor patient