J C Center for Psychiatric Services
43200 Dequindre Rd., Suite 103
Sterling Heights, MI 48314
Phone: (586) 799-4350
Fax: (586) 799-4279

NEW PATIENT REGISTRATION

PATIENT INFORMATION:

Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____ Cellular Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Emergency Contact Relationship (e.g. Spouse, Mother, etc.): _____

INSURANCE SUBSCRIBER INFORMATION:

Name: _____ Date of Birth: _____

Street Address: _____ City, State, Zip: _____

Home Phone: _____

Social Security Number: _____

Employer Name: _____ Employer Phone: _____

Employer Street Address: _____ City, State, Zip: _____

Primary Insurance Company Name: _____ ID #: _____

Group #: _____ Insurance telephone #: _____

Secondary Insurance Company Name: _____ ID #: _____

Group #: _____ Insurance telephone #: _____

MEDICAL INFORMATION RELEASE AND ASSIGNMENT OF BENEFITS:

I authorize the release of any medical information necessary to process this claim.
I hereby authorize Hany Mekhael, MD, PLLC to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Hany Mekhael, MD, PLLC. I certify that the information I have reported with regard to my insurance coverage is correct.
I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ Date: _____

Silver Oak South
43200 Dequindre Rd., Suite 103
Sterling Heights, MI 48314
Phone: (586) 799-4350
Fax: (586) 799-4279

EVALUATION INFORMATION

What is the reason for today's visit? _____

Who referred you to this clinic? _____

Previous psychiatrist(s): _____

Current therapist and frequency of therapy: _____

Previous psychiatric hospitalizations (list places and dates): _____

Previous medications for mental/behavioral health: _____

MEDICAL HISTORY AND INFORMATION

List any allergies to medications and the reaction that occurs: _____

Current medications (list all): _____

_____

Primary care physician and name and specialty of any other physician(s) treating you: _____

_____

List any previous surgeries or hospitalizations: _____

Do you smoke? ☐ No ☐ Currently: _____ packs per day ☐ Previously: _____ packs per day

Do you regularly drink alcohol? ☐ No ☐ Yes: _____ drinks per day

Do you regularly smoke marijuana? ☐ No ☐ Yes

Other drug use? ☐ No ☐ Yes

Females only: Are you pregnant, planning a pregnancy, or breastfeeding? ☐ No ☐ Yes

Have you ever had any of the following? (check all that apply)

- ☐ Arthritis
- ☐ Asthma
- ☐ Blood disorders
- ☐ Blood in stool
- ☐ Broken bones
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic pain
- ☐ Diabetes
- ☐ Dizziness
- ☐ Eczema
- ☐ Glaucoma
- ☐ Headaches
- ☐ Hearing difficulties
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Shortness of breath
- ☐ Skin disorders
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Memory loss
- ☐ Vision changes
- ☐ Weakness
- ☐ Weight changes

The information above is correct to the best of my knowledge.

Signature: _____ Date: _____