focusMD

APPOINTMENT REQUEST FORM – *adult & college*

Please complete this form so we can verify our clinic if appropriate for your needs

NAME OF PATIENT: First _____ Middle _____ Last _____

Date of Birth ___ / ___ / _____ Gender: __ Male __Female Preferred phone # (_____) _____ - _____

Are you currently a student? Yes No If yes, which school? _____ Employer: _____

What is the reason for the appointment request? _____

Is this a referral from another physician? Yes No If so what is the referring physician's name and address?

_____Phone # (___) ___- _____

Do you have a previous ADHD diagnosis? Yes No If "Yes" which professional made the diagnosis?

□ Psychologist □ Pediatrician □Family MD □Psychiatrist □Other _____

At the time of this diagnosis how old were you? _____ *yrs old OR* What grade were you in? _____

How was the diagnosis made? (check all that apply) □ Referral to psychologist

□ Interview by physician without testing □ Testing with Computer

□ Checklists completed by parents □ Full psychological and educational testing

□ Checklists completed by teachers □ Other _____

Are you currently under a physician's care for treatment of ADHD? Yes No

If "Yes," what is the reason for wishing to change from this physician or clinic? _____

What medications do you currently take for ADHD? _____

What medications have you taken in the past for ADHD? _____

OTHER CONDITIONS: For which other emotional / behavior health conditions has patient been treated or diagnosed?

Depression Generalized anxiety disorder Social anxiety disorder Obsessive compulsive disorder

Bipolar disorder Autism spectrum disorder (including "Aspergers") Disorder of sleep / Insomnia

Other _____

Current medications for mood / behavioral health conditions: _____

Previous medications for mood/ behavioral health conditions: _____

What other long-term medical problems do you have? _____

What other medications do you take? _____

INSURANCE:

Name of Guarantor _____ Phone # (__) ___- _____ Relationship to patient _____

Mailing Address: □ *same as patient* _____ _____

City _____ State _____ Zip _____

Insurance Carrier _____Contract # _____ Group #_____

Name of Insured *(if different)* _____ Benefits/Eligibility Phone # (____) ____- _____ *(on back of insurance card)*

options for returning the completed form

► **FAX:** 877-794-2293 *(secure)*

► **E-MAIL:** Tuscaloosa.appointments@focus-MD.com *(non-secure)*

► **MAIL:** Tuscaloosa Focus-MD
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