Stacey Laird, MD, LLC

4121 West 83rd Street, Suite 204, Prairie Village, KS 66208 | (913)283-7095 | FAX: 913-242-7060

PATIENT INFORMATION FORM

Please Print Date Completed ________________

Legal Name: ________________________________DOB: ____________ Gender: ☐M ☐F

Address: ______________________________ City: ____________ State:_______ Zip: ________________

Home Phone: ______________________Work Phone: ______________ Email_________________________

Occupation ___________________Employer: ___________Social Security ___________________

Marital Status: _____________Years of Education/Degree: ___________General Health: ____________________

Ethnicity: _________________ Race _________________Preferred Language: ____________________________

Emergency Contact:

Name:____Relationship: ________________________________

Home Phone: __________________Work Phone: _________________________Cell: _____________________

Preferred Pharmacy:

Name:____ Telephone: ___________________________________

Address: ______________________________ City: ____________ State:_______ Zip: ________________

Primary Insurance Information

Insurance Company:____ Phone: ______________________

Ins. Address: ___________________________ City: ____________ State:_______ Zip: _____________

Policy Number or Holder's SSN: ____________________________________ Group No. ____________________

Policy Holder: ______________________ DOB: __________________Relationship:______________________

Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the doctor or doctor's group, insurance benefits otherwise payable to me.

I understand that my insurance carrier may pay less than actual billed charges for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents.

✘ ____

Signature of patient Date

REASONS FOR EVALUATION

Who referred you to our practice? Name: ______________________ Phone: ____________________

Please state your concerns; specify nature of problem, onset, duration, frequency, and severity: ______________

____

Any unusual stressor your family is experiencing: ______________________________________

____

What do you hope to get from this evaluation/treatment? ______________________________

MEDICAL/PHYSICAL HISTORY

Who is your primary Physician? Name: ______________________ Phone: ______________

Address: ______________________ City: ______ - ________ State: ________ Zip: ________

When were you last seen by a physician? __________ Reason? ______________________________

Date and results of last physical examination: ____________ Current Height: __________ Current weight: ____________

General physical health good? ☐ Yes ☐ No

Do you have OR had (please check and include details):

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Colitis
- ☐ Reflux/GERD/Ulcer
- ☐ Migraines
- ☐ Blood Transfusion
- ☐ Cancer of __________
- ☐ Diabetes, type ________
- ☐ Thyroid problems
- ☐ Arthritis
- ☐ Lupus
- ☐ Mental Illness
- ☐ Personality Disorder
- ☐ Anxiety
- ☐ Head Injury
- ☐ Kidney Disease
- ☐ Headache, non-migraine
- ☐ Asthma
- ☐ Chronic Lung Disease
- ☐ Osteoporosis
- ☐ Gallbladder problems
- ☐ Liver Disease or Hepatitis
- ☐ Glaucoma
- ☐ Anemia
- ☐ Abuse type ____________
- ☐ Weight Loss
- ☐ Previous Surgery
- ☐ Blood Clotting Disorder
- ☐ DVT
- ☐ Mitral Valve
- ☐ High Cholesterol
- ☐ Bleeding Disorder
- ☐ Epilepsy or Seizures
- ☐ Drug Problem
- ☐ Alcohol Problem
- ☐ Depression

Psychiatric:

- ☐ Problems with sleeping?
- ☐ Appetite change or sudden weight change?
- ☐ Irritability or temper outbursts?
- ☐ Depressive statements (for example: "I wish I was dead.")?
- ☐ Not coping in school like before?
- ☐ Withdrawn or prefers being alone?
- ☐ Frequent complaints of aches or pains?
- ☐ Recent drop in grades?
- ☐ Phobia or irrational fears?
- ☐ Difficulties separating from you?
- ☐ Bouts of severe anxiety or panics?
- ☐ Repetitive behaviors (for example: washing hands, checking locks)?
- ☐ Pulling out hair or eyelashes?
- ☐ Episodes of unusually high or talkativeness?
- ☐ Attention problems?
- ☐ Impulsive behaviors?
- ☐ Easily distracted from what he/she is doing?
- ☐ Hyperactive according to the teacher?
- ☐ Abnormal movements (for example: jerking or eye blinking)?
- ☐ Excessive noises (for example throat clearing or sniffing)?
- ☐ Bossy?
- ☐ Refuses to do what he/she is told?
- ☐ Problems with the law?
- ☐ Expelled or suspended from school?
- ☐ Running away from home?
- ☐ Setting fires?
- ☐ Hurting animals or other people?
- ☐ Stealing?
- ☐ Abnormal lying?
- ☐ Smoking?
- ☐ Drinking?
- ☐ Illegal drug use?
- ☐ Inappropriate sexual behavior?
- ☐ Ever been sexually abused?
- ☐ Ever been physically abused?
- ☐ Slow to learn?
- ☐ Ever suspected having intellectual difficulty
- ☐ Ever suspected of being autistic?
- ☐ Plays with toys or other objects in Unusual ways?
- ☐ Head bangs, flaps. Twirls, bites or Hits?
- ☐ Resistant to change?
- ☐ Talks to him/herself?
- ☐ Have any imaginary friends?
- ☐ Ever appear to be hearing Voices or seeing visions?
- ☐ Paranoid or afraid of others?
- ☐ Have off ideas or beliefs?
- ☐ Tried to kill themselves or others?

Provide Details:
____
____

Surgical History (type and date): example: appendix 2007; c-section 2003
____
____
____

Current Medication List:

Name of medication(s):	Dose/Schedule:	Conditions:	Prescribing MD:	Response/side effects:

Medication Allergies: ☐ **No Known allergies**

Name of medication(s):	Response/side effects:

FAMIILY MEDICAL/PSYCHIATRIC HISTORY

Please check if anyone in the Family have any of the following conditions? If so, please list family member: i.e. Mother, Father, Sibling etc.

- ☐ Mental Retardation ____________________
- ☐ Learning disorder ____________________
- ☐ Attention Deficit ____________________
- ☐ Hyperactivity ____________________
- ☐ Epilepsy ____________________
- ☐ Neurological Disorders ____________________
- ☐ Alcohol Abuse ____________________
- ☐ Drug Abuse ____________________
- ☐ Physical/Emotional Abuse ____________________
- ☐ Sexual Abuse ____________________
- ☐ Depression ____________________
- ☐ Suicidal attempt ____________________
- ☐ Anxiety Disorders ____________________
- ☐ Specific Fears or Phobias ____________________
- ☐ Panic Attacks ____________________
- ☐ Schizophrenia ____________________
- ☐ Visual Disability/Problems ____________________
- ☐ Deaf/Hard of Hearing ____________________
- ☐ Tics/Tourette's Syndrome ____________________
- ☐ Chronic Illnesses ____________________
- ☐ Juvenile Delinquency ____________________
- ☐ Arrests/Incarceration ____________________
- ☐ Harassment by peers ____________________
- ☐ Homelessness ____________________
- ☐ Teen Pregnancy ____________________
- ☐ School suspension/expulsion ____________________
- ☐ Special Education ____________________
- ☐ Birth Defects ____________________
- ☐ Miscarriages ____________________
- ☐ Other: ____________________

- ☐ Heart Disease ____________________
- ☐ High Cholesterol ____________________
- ☐ High Blood Pressure ____________________
- ☐ Bleeding disorder ____________________
- ☐ Asthma ____________________
- ☐ Kidney Disease ____________________
- ☐ Lupus ____________________
- ☐ Stroke ____________________
- ☐ Diabetes ____________________

☐ Arthritis ___________________________________

☐ Cancer ___________________________________

Type:____________________________

☐ Sudden death from cardiac reason: ________________

Are there any problems in the home, If yes, then please specify:

Divorce	☐Yes	☐No
Violence or abuse	☐Yes	☐No
Drugs	☐Yes	☐No
Alcohol	☐Yes	☐No
Financial difficulties	☐Yes	☐No
Eviction/Foreclosure	☐Yes	☐No
Court cases/legal problems	☐Yes	☐No
Unemployment	☐Yes	☐No

AUTHORIZATION, RELEASE AND FINANCIAL POLICY

I hereby authorize psychiatric evaluation and treatment with Stacey Laird, MD

By signature below, I agree to the following statements:

1. I have been given information regarding my rights and responsibilities as a patient.
2. I have been given information regarding the limits of confidentiality of my records.
3. I understand that it is the financial policy of this office that payment is made at the time services are rendered. For any missed appointments, in which 24 hours notice is not given, the full charge for the visit will be charged to the patient. For those insured by an insurance company that we contract to participate, we will adhere to the terms of the contract and will file the necessary claims. For insurance companies which we are not contracted with, payment will be expected at the time of service. Additionally, we charge 45.00 per returned check or disputed credit card charge.
4. I am freely choosing to enter into treatment, and I understand that I may address any concerns or grievances with my physician at any time.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of my physician regarding the above information at any time.

✘ ____

Signature of patient Date

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by Stacey Laird, MD, LLC, or disclosed to others for the purposes of treatment, obtaining payment, or supporting day to day health care operations of the practice. You may review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If Stacey Laird, MD, LC agrees to your request, the restriction will be binding on the practice. You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use ore disclosure that has already occurred prior to the date on which your revocation consent is received will not be affected. Stacey Laird, MD, LLC reserves the right to modify the practices outlined in this notice.

Communication with the patient above should be directed to: (Check all that apply)

☐ Home phone-Patient	☐ Home phone-Family Member	☐ Answering Machine- Home
☐ Office Phone- Patient	☐ Office Phone- Voice mail	☐ Mail

Specific Person by any of the above methods____

Name Relationship

I have reviewed this consent and give my permission to Stacey Laird, MD, LLC to use and disclose my health information in accordance with it.

✘ ____

Signature of patient Date