

# Stacey Laird, MD, LLC

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## PATIENT AND FAMILY INFORMATION FORM

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Ethnicity/Race: \_\_\_\_\_ Primary language: \_\_\_\_\_

**Mother/Maternal Caregiver Information:** Relationship to child:  biological  adoptive  foster  step  other

Mother's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

**Father/Paternal Caregiver Information:** Relationship to child:  biological  adoptive  foster  step  other

Father's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

### 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.

**x** \_\_\_\_\_  
Signature of patient or parent if minor 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? \_\_\_\_\_

## CHILD'S MEDICAL/PHYSICAL HISTORY

Who is the child's primary Physician? Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ - State: \_\_\_\_\_ Zip: \_\_\_\_\_

When was your child last seen by a physician? \_\_\_\_\_ Reason? \_\_\_\_\_

Date and results of last physical examination: \_\_\_\_\_ Current Height: \_\_\_\_\_ Current weight: \_\_\_\_\_

Is the child's general physical health good?  Yes  No

Are immunizations up to date?  Yes  No

Does Child have OR had (please check and include details):

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

### Psychiatric:

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

Provide Details:

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

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**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:

**FAMILY 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 \_\_\_\_\_

Sudden death from cardiac reason: \_\_\_\_\_

Cancer \_\_\_\_\_

Type: \_\_\_\_\_

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

- |                                   |                              |                             |
|-----------------------------------|------------------------------|-----------------------------|
| <b>Separation of parent</b>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Divorce</b>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Violence or abuse</b>          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Drugs</b>                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Alcohol</b>                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Financial difficulties</b>     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Eviction/Foreclosure</b>       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Court cases/legal problems</b> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <b>Unemployment</b>               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**AUTHORIZATION, RELEASE AND FINANCIAL POLICY**

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

\_\_\_\_\_, \_\_\_\_\_  
Child's Name Child's DOB

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 of my child. I also attest that I am the legal guardian and have the right to consent for treatment of this child. I understand that I have the right to ask questions of my child's physician regarding the above information at any time.**

**x**

\_\_\_\_\_  
Signature of patient or parent if minor

\_\_\_\_\_  
Date

