Tasel Health

Patient Registration Sheet

Patient Information

Patient First Name	MI	Last Name

Address	City	State, Zip

Age	DOB	Social Security #	Sex	Marital Status
			☐M ☐F	☐Single ☐Married ☐Divorced ☐Widowed

Home Phone: Cell Phone: Work Phone:

Employment: ☐ Full-Time ☐Part-Time ☐Unemployed ☐Retired ☐Military ☐Full Time Student

Employer: Employer Address:

Would you like to receive communication by email? ☐Y ☐N Email address:

Would you like information on Advanced Directives (over 18 yrs)? ☐Y ☐N

How did you hear about us? ☐Drive-by ☐Insurance Referral ☐Online ☐Friend:_____ ☐Other:_____

Minor

Name of Parent or Legal Guardian: Contact Phone Number

Primary

Insurance:	ID#:	Group#:	$ Co-pay:	$Deductible:

Address:	Insurance Phone :

Name of Primary Insured Person:	DOB:	SS#:	Relationship to Patient: ☐Self ☐Spouse ☐Parent

Insured's Employer: Address: Phone:

Secondary

Insurance:	ID#:	Group#:	$ Co-pay:	$Deductible:

Address:	Insurance Phone:

Name of Primary Insured Person:	DOB:	SS#:	Relationship to Patient: ☐Self ☐Spouse ☐Parent

Insured's Employer: Address: Phone:

Emergency

Emergency Contact: Phone: Relationship to Patient:

☐Friend ☐Spouse ☐Parent

Okay to give confidential information? ☐Y ☐N

Please Read Carefully: I hereby **CONSENT FOR TREATMENT** by the providers of this practice and authorize the release of any medical information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to my healthcare provider. I agree this authorization will cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original. I understand that I am ultimately responsible for payment of services. I am aware that in Oklahoma, records that are released may include, but are not limited to, information regarding communicable diseases such as HIV/AIDS.

I understand that this healthcare facility will bill my insurance as a courtesy. I am responsible for copayments, non-covered services, coinsurances, etc. If this facility does not receive payment within 60 days from the insurance company, I will be billed and no other services will be available through this facility until my account is paid in full. I understand that if my account is turned to outside collections, I will be responsible for all costs of collections, fees, court costs, accrued interest, etc., and this may be reported to a major credit bureau.

☐ I have been informed about and received notice regarding the Privacy Practices in place at this facility. I understand the Uses and Disclosure policies governing my personal health information. I understand that these notices and policies are prominently posted throughout this facility and that I may receive a personal copy *upon request*.

☐ I hereby give permission to release all necessary records in the event of a healthcare referral.

☐ I hereby authorize this practice to discuss my protected healthcare information with this named person: _____.
Relationship:_____. This authorization shall remain in place until: Date_____ ☐indefinitely. ☐ I authorize Myself Only.

Signature:_____ **Date:** _____ ☐Self ☐Guardian

Tasel Health

Patient History

Patient info

Today's Date:	Patient Name:	DOB	Previous Medical Provider:
Type of Work		How long?	
Highest Level of Education: (circle one) Elementary Middle School High School College			
Number and ages of Children:			

Med List

Medication	Dose/ Strength	Reason for Taking	Prescribing Doctor

Ever been hospitalized for mental health issues?	☐Y ☐N	If yes… How many times have you been inpatient?____
What facility?		Did you follow-up with a doctor when you left? ☐Y ☐N
Are you currently having thoughts of suicide?	☐Y ☐N	If yes, explain
Have you had thoughts of hurting yourself or others in the past?	☐Y ☐N	If yes, explain

IN THE PAST MONTH, have you experienced any of the following:

1	Depressed Mood	☐Y ☐N	10	Racing Thoughts	☐Y ☐N	19	Excessive Worry	☐Y ☐N
2	Increased risky behavior	☐Y ☐N	11	Anxiety Attacks	☐Y ☐N	20	Suicidal Thoughts	☐Y ☐N
3	Decreased need for sleep	☐Y ☐N	12	Hallucinations	☐Y ☐N	21	Forgetful	☐Y ☐N
4	Fatigue	☐Y ☐N	13	Excessive Energy	☐Y ☐N	22	Thoughts of harming self or others	☐Y ☐N
5	Poor Concentration	☐Y ☐N	14	Decreased libido	☐Y ☐N	23	Increased libido	☐Y ☐N
6	Suspiciousness	☐Y ☐N	15	Increased Irritability	☐Y ☐N	24	Unable to enjoy activities	☐Y ☐N
7	Crying Spells	☐Y ☐N	16	Loss of Interest	☐Y ☐N	25	Little Pleasure in Relationships	☐Y ☐N
8	Impulsivity	☐Y ☐N	17	Change in Appetite	☐Y ☐N	26	Excessive Daytime Drowsiness	☐Y ☐N
9	Sleep Difficulty	☐Y ☐N	18	other	☐Y ☐N	27	other	☐Y ☐N

Signature:_____ **Date**: _____ ☐Self ☐Guardian