Ivy Collaborative Healthcare | PRIVIA MEDICAL GROUP

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New Patient Visit Information (supplement)

Name of person completing this form:_____ **Relationship to patient:**_____

Patient's Legal Name (First, MI, Last, Suffix): _____

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone (main): _____ Consent to leave a message and/or text? ☐Yes ☐No

Alt Phone: _____ Consent to leave a message and/or text? ☐Yes ☐No

Primary Email: _____ Please note that email is not considered to be a confidential medium of communication

May we email you? ☐Yes ☐No Contact Preference: cell, home phone, email? (circle one)

Spouse/Emergency Contact: _____ Relationship: _____

Address: ☐(check if same as patient) _____

City: _____ State: _____ Zip: _____

Patient Demographics:

DOB:(mm/dd/yyyy): _____ Age: _____

Guarantor Demographics (who is Primary on Insurance)

Guarantor name: _____ DOB:(mm/dd/yyyy): _____

Mobile Phone (main): _____ Consent to leave a message? ☐ Yes ☐ No

Email: _____

Employer: _____ Patient's relationship to guarantor: _____

Guarantor's Mailing Address: ☐ (check if same as patient)

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance:

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Subscriber (Primary on Insurance): _____ Relationship: _____

Secondary Insurance (if applicable): ☐ None

Company Name: _____ Phone: _____

Address (may be a PO Box): _____

City: _____ State: _____ Zip: _____

ID#: _____ Group #: _____

Subscriber (Primary on Insurance): _____ Relationship: _____

List any recent family difficulties or upsetting events (ex. Illness or death of a family member or close relative, moves, financial challenges, marital stress, abuse (emotional/sexual/physical)? _____

_____

_____

Current Medical Illnesses: _____

Previous Psychiatric Diagnoses: _____

Previous Psychiatric Medication trials:

Medication	Dose	Frequency	Duration of treatment (ex. days, weeks, months, years)	Side Effect(s)
1				
2				
3				
4				
5				

Psychiatric Hospitalizations and/or Residential Treatment:

Dates	Hospital	Reason

Social History:

Family Members at home (spouse, parents, children, siblings and/or other relatives):

1. Name _____ Relationship to the patient: _____
2. Name _____ Relationship to the patient: _____
3. Name _____ Relationship to the patient: _____
4. Name _____ Relationship to the patient: _____
5. Name _____ Relationship to the patient: _____

Education: _____ Highest grade completed

Occupation: Currently Working? ☐Yes, where: _____ ☐ No ☐ On Disability ☐ Retired

Smoking History: ☐Never smoked ☐ Former Smoker ☐ Current Smoker _____ packs per day

Signature Acknowledgement

Your signature serves as a comprehensive signature acknowledgement for the following forms and policies. Please access the patient portal to review and print your documents or they can be printed for you upon request. You further acknowledge that you have read, understand and accept each policy in its entirety.

✓ **HIPPA Privacy Notice** ✓ **Financial Policies** ✓ **Notice of Privacy Practices**

Patient Signature: _____ **Date:** _____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)