NEW PATIENT INTAKE FORM

If you are interested in setting up an appointment for assessment/evaluation, please complete this form and fax to 520-334-2006. Someone will call you to discuss your needs further and schedule an appointment. Note: Dr. Beldotti is accepting new patients for assessments but is NOT taking any patients for emergency/crisis evaluations or counseling.

Patient Name: ___________________________________ Age: _____ DOB: ___________

Best contact person: ________________________________ Tel: _____________________

Email: ____

Full address of pt: ____

City: _____________________________ State: ________ Zip: __________________

School Info (if applicable): Grade: _______ School: _______________________________

Referred by: ____

Reason for Referral / Reason for evaluation (include as much detail as possible):

____

____

____

____

Does the person have any history of depression, anxiety, trauma, ADHD, Autism, thinking or learning problems (if yes, what): ____________________________________

____

____

Is person currently receiving counseling? _____________________________________

If yes: How long and who is provider:_______________________________________

Any history of inpatient psychiatric treatment? ________________________________

Any problems with being violent or aggressive __________________________________

Any history of head injuries, stroke, seizures, etc.: ______________________________

____

Any problems with addiction/ substance abuse (if teen/adult): ____________________

Any current medication for ADHD/Psych: _____________________________________

If yes, please list medications and who is prescribing them: ______________________

____

Any medications that cause drowsiness: ______________________________________

Does person have any problems with vision or hearing:__________________________

____

Can person speak and communicate okay: ____________________________________

Is there anyone's permission we need to do evaluation (guardian, other parent if divorced, etc.) ____

Any other relevant history or info: ____

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Note: depending on reason for assessment, insurance may cover some or all of the assessment. If you would like more done than your insurance will cover, we can give you an estimate of additional costs.

Issues that you would like assessed (list in order of priority, starting with #1):

____ ADD/ADHD _____ Autism / Aspergers _____ IQ _____ Development Delay

____ Cognitive (thinking, attention, memory, etc.). _____ Possible Dementia

____ Academic skills (note: insurance does not cover this, would be private pay)

____ Psychological (mood, anxiety, depression, etc.). ____________________________________

Other: ____

Payor Info: ____ Private Pay ____ 3rd Party: ______________________________________

____ Worker's Compensation: ____
Contact info:

Insurance: ____ BCBS AZ

____ Aetna

____ United Healthcare / United Behavioral Health

____ Tricare (United Military)* (*Need referral from MD)

____ Cigna

____ Aetna Medicare PPO (I cannot take if HMO version)* (*Need referral from MD)

____ Medicare (traditional)* (*Need referral from MD)

____ Medicare Advantage* (*Need Referral from MD)

____ Other insurance as Out-of-Network provider (pt must pay for service & get reimbursed)

Note: I am not accepting MHN/HealthNet any longer
Note: I am not covered under all the government health plans, even if under one of the companies I am contracted with (i.e., United, etc.). Please call your plan to check.
Note: I cannot accept Medicaid / AHCCCS. Please contact one of the mental health agencies for any needed services (i.e., La Frontera, etc.)

If you are using insurance, you must fill out attached insurance form before appt will be scheduled.

INSURANCE INFORMATION

Name of Patient: ____

Gender: __ Male __ Female   Date of Birth: ___________________ Age: _______

Address: ____

City: ________________________________ State: _________ Zip: __________________

Telephone: ____

Who is the insurance plan under (Insured person)?

Name: ____

Gender: __ Male __ Female   Date of Birth: ___________________

Address: ____

City: ________________________________ State: _________ Zip: __________________

Telephone: ____

Employer: ____

Relationship to patient: ___ Self ___ Spouse ___ Child /Dependent

Name of Insurance: ____

ID #: ____

Group Name/#: ____

Any other ID #'s: ____

Insurance telephone (for Providers): ____

Is there Secondary Insurance? __ No __ Yes (fill out another page for this)