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: _____

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 medical conditions or 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 in English: _____

Is English the primary language spoken: _____

Is this evaluation request related to any current legal issues: _____

_____

Any other relevant history or info: _____

_____

_____

FOR ADULTS:

Currently on disability? _____ If yes, what for: _____

Currently on worker's comp: _____

Currently employed (what, where): _____

FOR CHILDREN & ADOLESCENTS:

Mother's Name: _____ Tel: _____

Mother's Email: _____ Lives with child? _____

If not, Mother's address: _____

Father's Name: _____ Tel: _____

Father's Email: _____ Lives with child? _____

If not, Father's address: _____

Other Guardian: _____ Tel: _____

Guardian's Email: _____ Lives with child? _____

Who has physical custody of the child: _____

_____

Who has decision-making abilities regarding the child: _____

_____

School Info: Grade: _____ School: _____

Any Special Education services / IEP / 504 Plan? _____

_____

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: _____

INSURANCE INFORMATION

***The only insurance accepted is Tricare, Medicare (non-AHCCCS) & WC (w/agreement)**
*****Referral required for all of these**

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: _____

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

Name of Insurance: ___ Tricare ___ Medicare (non-AHCCCS) ___ WC

ID #: _____

Group Name/#: _____

Any other ID #'s: _____

Insurance telephone (for Providers): _____

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