FRONT RANGE PSYCHIATRY

NEW PATIENT INFORMATION FORM

Heather Newman, MD

Your Name: _____
Date of Birth: _____
Address_____
City_____ State_____ Zip _____
Phone: _____
E-mail: _____
Preferred pharmacy name and address or phone # _____
Marital Status: _____
Employer & Position: _____
Emergency contact: _____
Insurance company: _____

Medical History:

Current Medications (include supplements/vitamins/herbs/birth control): _____
_____
_____
_____

Current Primary Care Physician (name of provider and phone number)
_____
_____

Psychiatric History:
Diagnoses & past treatment (briefly): _____
_____
_____
_____
_____

FRONT RANGE PSYCHIATRY

Psychiatric medications tried:

_____

_____

_____

History of suicide attempts and psychiatric hospitalizations (approx. dates, name of hospital):

_____

_____

_____

Payment Information Summary:

Professional Fees:

- New patient evaluation, Adult, age 17 and up, 60-75 min $350
- Medication management visit, 30 minutes $175

Cancellation Policy:

Appointments cancelled or rescheduled with at least **48 business-hours'** notice will not be charged. Cancelled or rescheduled appointments with less than 48 business hours' notice or missed/no-show appointments will be charged in full. New patients must pay with a credit card in advance for the first appointment, and a credit card must be kept on file for any missed future appointments.

_____ _____

Signature required (patient or guardian) Date

_____

Printed name of patient (or representative and relationship to patient)