MICHIGAN STATE UNIVERSITY
HEALTHTEAM

Date _____ MRN _____ (For Office Use Only)

PATIENT INFORMATION

Patient Name _____ SS# _____
Last First M.I.

Age _____ Date of Birth _____ Male Female Marital Status _____ Email _____

Address _____
Street/Apt # City State Zip Code

Phone: Home _____ Work _____ Cell _____

Occupation _____ Employer _____

Employer's Address _____
Street City State Zip Code

MSU Student? Yes No If Yes, Student # _____ MSU Athlete? Yes No

Emergency Contact Person #1 _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Emergency Contact Person #2 _____ Relationship _____

Phone: Home _____ Work _____ Cell _____

Primary Care Physician _____ Telephone _____

Address _____
Street City State Zip Code

Referring Provider (if not PCP) _____ Telephone _____

Address _____
Street City State Zip Code

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS A MINOR)

Person Responsible for Payment _____
Last First M.I.

Date of Birth _____ SS# _____ Relationship to Patient _____

Address – **Same as Patient** ☐ _____
Street/Apt # City State Zip Code

Phone: Home _____ Work _____ Cell _____

Employer _____ Address _____
Street City State Zip Code

Other Parent's Name _____ Date of Birth _____
Last First M.I.

Other Parent's Address – **Same as Patient** ☐ _____
Street/Apt # City State Zip Code

Other Parent's Phone: Home _____ Work _____ Cell _____

INSURANCE INFORMATION

INSURANCE PLAN ____ Effective Date _______________ Primary ___ Secondary ___

Insurance Plan Address ____

Insurance Plan Phone# ____________________ Auth/Precert Phone# ____________________ Customer Service Phone# __________________

Name of Policyholder ____ Date of Birth _______________ Gender ______

Employer & Address ____

SSN __________________________ Relationship to Patient ________________________________

Policyholder Address/Phone # ____

Contract/ID/Group # ____ Service Plan # _____________ Coverage Type _________________

Primary Care Copay ____________ Specialty Copay ____________ Mental Health Copay ____________ PT/SP/OT Copay ____________

INSURANCE PLAN ____ Effective Date _______________ Primary ___ Secondary ___

Insurance Plan Address ____

Insurance Plan Phone# ____________________ Auth/Precert Phone# ____________________ Customer Service Phone# __________________

Name of Policyholder ____ Date of Birth _______________ Gender ______

Employer & Address ____

SSN __________________________ Relationship to Patient ________________________________

Policyholder Address/Phone # ____

Contract/ID/Group # ____ Service Plan # _____________ Coverage Type _________________

Primary Care Copay ____________ Specialty Copay ____________ Mental Health Copay ____________ PT/SP/OT Copay ____________

INSURANCE PLAN ____ Effective Date _______________ Primary ___ Secondary ___

Insurance Plan Address ____

Insurance Plan Phone# ____________________ Auth/Precert Phone# ____________________ Customer Service Phone# __________________

Name of Policyholder ____ Date of Birth _______________ Gender ______

Employer & Address ____

SSN __________________________ Relationship to Patient ________________________________

Policyholder Address/Phone # ____

Contract/ID/Group # ____ Service Plan # _____________ Coverage Type _________________

Primary Care Copay ____________ Specialty Copay ____________ Mental Health Copay ____________ PT/SP/OT Copay ____________

WORKERS COMPENSATION / AUTO LIABILITY _______ Primary _______ Secondary Authorization Required? Yes No

Carrier ____ Case/Claim # ____________________________

Claims Address ____

Phone # ____ Contact Person ____

Date of Injury/Accident _________________________________

Michigan State University
Department of Psychiatry

Psychiatric Assessment Services for Children and Adolescents
Returning Patient Information

INSTRUCTIONS:

Please complete this form regarding your child's current status and include anything that has changed in the history since your child was last seen in our clinic on _____.

For Office Use Only

BP: _____

Height: _____

Weight: _____

IDENTIFYING INFORMATION

Child's Name		Sex: □ Male □ Female	Date
Date of Birth	School	School Grade	
Address	Telephone	Religion (optional)	
Your Name		Relationship to Patient □ Father □ Mother □ Guardian □ Grandparent	
Chief Complaint:			

PSYCHIATRIC TREATMENT

Since last appointment with us, has the child been seen by a Psychiatrist or Psychologist or been hospitalized for emotional or behavioral problems? □ Yes □ No
If yes, please give name of Psychiatrist/Psychologist and/or hospital and reason for treatment.

_____

_____

MEDICAL HISTORY

Since last seen has child:

Had any childhood diseases (measles, chicken pox, whooping cough or mumps)? □ Yes □ No
Been treated for an emergency? □ Yes □ No Please explain_____
Suffered any accidents? □ Yes □ No Please explain_____
Had any surgeries? □ Yes □ No Please explain_____
Has the child suffered with any new problems listed below?

□ Allergies	□ Anemia	□ Arm Problems	□ Poor Appetite
□Arthritis	□ Asthma	□ Backaches	□ Sinus Trouble

□ Broken Bones □ Colds or Flu □ Colic □ Rheumatic Fever
□ Constipation □ Convulsions □ Diabetes □ Sugar Levels
□ Diarrhea □ Digestive Problems □ Dizziness □ Ruptures or Hernias
□ Earaches □ Ear Infections □ Fainting □ Tuberculosis
□ Growing Pains □ Headaches □ Heart Trouble □ Walking Problems
□ Hypertension □ Joint Problems □ Leg Problems □ Strep Throat
□ Muscle Jerking □ Neck Problems □ Paralysis □ Head Injury
□ Other: _____

Is the child up to date with his/her vaccinations? □ Yes □ No □ I don't know

When was the child last seen by his/her physician?_____
What was the purpose of that visit?_____

Is the child taking any medications at this time? □ Yes □ No
If yes, please list the medications and dose: _____
_____
_____

Has the child taken any medications for hyperactivity, attention problems, behavior problems or mood problems? □ Yes □ No
If yes, please list the medications and dose: _____

DEVELOPMENTAL HISTORY

Has anything changed since last seen? ***Yes_____*** ***No_____***
(If yes, please complete remainder of this section.)

Educational History:

	Name of School	City/State	Dates Attended Begin	End	Grades completed at this school
Preschool					
Elementary					
Junior High					
High School					

Type of Classes: □ Regular □ Home School □ Emotionally Impaired □ Other_____
□ Alternative HS □ Resource Room □ Learning Impaired _____

Did the child skip a grade? □ Yes □ No Repeat a grade? □ Yes □ No
If yes, when and how many years _____

Did child have any specific learning difficulties? □ Yes □ No
If yes, has any testing been done, describe?_____

PSYCHOSOCIAL HISTORY

Has anything changed since last seen? ***Yes_____*** ***No_____***
(If yes, please complete remainder of this section.)

Marital History of Parents: Natural Parents: □ Married when _____ age _____
□ Separated when _____
□ Divorced when _____
□ Deceased Mother when _____ Father when_____
Step Parents: □ Married when _____

Living Arrangements: Places Dates
Number of moves since last seen _____ _____
_____ _____

Present home □ house □ apartment □ rent □ own

Does Child Share a room □ Yes □ No If yes with whom & relationship_____
If no, how long with own room _____

Others living in the home (and their relationship:)
1. _____
2. _____
3. _____

Has the child lived away from the family? □ Yes □ No
Explain _____

What are the major family stresses at the present time, if any? _____
_____

What are the sources of family income? _____
_____

Brothers & Sisters since last visit (indicate if step brothers or step sisters)

Name	Age	Sex	School or Occupation	Present Grade	Living at Home	Use drugs or alcohol	Treated for Drug abuse	Treated for mental illness
1.		□ M □ F			□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
2.		□ M □ F			□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
3.		□ M □ F			□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
4.		□ M □ F			□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
5.		□ M □ F			□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
6.		□ M □ F			□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No

Does or did any member of the child's family have any problems with: □ reading □ spelling □ math
□ speech (if yes, please explain) _____

FAMILY HISTORY

Please indicate any member of the child's family who has had any of the following problems since last seen:

Depression/Suicide: _____Anxiety:_____
Obsessive Compulsive Disorder: _____Bipolar Disorder:_____
Attention Deficit Disorder: _____Mental Retardation:_____

Schizophrenia: _____Alcohol Problems:_____Drug Use/Problems: _____ Learning Problems:_____
In trouble with the law: _____Abuse or Neglect:_____

Has any member of the family been on psychiatric medication?_____
Other Problems: _____

SUBSTANCE ABUSE

Do you have any concerns about your child using drugs or alcohol? □ Yes □ No

If yes, please explain_____

LEGAL HISTORY

Has anything changed since last seen? ***Yes_____*** ***No_____***
(If yes, please complete remainder of this section.)

Has the child been arrested? □ Yes □ No
If yes, describe_____

Has the child been in trouble with the police? □ Yes □ No
If yes, describe_____

Has the child been involved with the juvenile court? □ Yes □ No
If yes, describe_____
Name of Probation Agent_____Name of Attorney (if any)_____

Has the child been involved with the circuit or district courts? □ Yes □ No
If yes, describe_____
Name of Probation Agent_____Name of Attorney (if any)_____

Your Name:_____ Date:_____

Patient	
MRN	

MSU Psychiatry Clinic

No-Show Policy

Quality care for our patients is our top priority. Please take a few minutes to review our No-Show policy and sign at the bottom of the form. If you have any questions, please let us know.

Definition of a No-Show Appointment

MSU Psychiatry Clinic defines a No-Show appointment as any scheduled appointment in which the patient either:

- Does not arrive to the appointment.
- Cancels with less than 24 hours' notice.
- Arrives more than 10 minutes late and is consequently unable to be seen.

Impact of a No Show Appointment

No-show appointments have a significant negative impact on our practice and the healthcare we provide to our patients. When a patient fails to show up for a scheduled appointment it:

- Potentially jeopardizes the health of the patient.
- Is unfair (and frustrating) to other patients who would have taken the appointment slot.
- Is disrespectful of the provider's time.

How to Avoid Getting a No-Show

1. **Confirm** your appointment
2. **Arrive** 5-10 minutes early
3. **Give 24 hours'** notice to cancel appointment

1. Appointment Confirmation

MSU Psychiatry Clinic will attempt to contact you 2-3 business days before your scheduled appointment to confirm your visit. If our automated system is unable to confirm with you over the phone, we will leave a message with your appointment date and time.

2. Always Arrive 5-10 Minutes Early

When you schedule an office visit with us, we expect you to arrive at our clinic 5-10 minutes prior to your scheduled visit. This allows time for you and our staff to address any insurance or billing questions, and to complete any necessary paperwork before the scheduled visit.

3. Give 24 Hours' Notice if You Need to Cancel

When you need to cancel or reschedule an appointment, we expect you to contact our office no later than 24 hours before the scheduled visit. This allows us a reasonable amount of time to determine the most appropriate way to reschedule your care, as well as giving us the opportunity to rebook the vacant appointment slot with another patient. If it is less than 24 hours before your appointment and something comes up, please give us the courtesy of a phone call at 517-353-3070.

Consequences of No-Show Appointments

1. You will be charged a $50 no-show fee for each missed appointment.
2. If you miss 3 or more appointments within a year, you will be discharged from the clinic.
3. If you are discharged from the clinic, your remaining scheduled appointments will be cancelled.
4. Only emergency medical treatment will be offered within the first 30 days of discharge.

I have read and understand the MSU Psychiatry Clinic No Show policy as described above.

Patient/Guardian Signature _____ Date _____