REGISTRATION (please print)

BARRY K. HULL, M.D.
A New Start Medical Center, Inc.
115 Habersham Drive, Fayetteville, GA 30214
678-788-7500 phone / 678-788-7501 fax

PATIENT INFORMATION

DATE: _____ Preferred Contact number:_____ OK to leave message? ☐YES / ☐NO

Patient Name: _____ Date of Birth: _____ Age: _____

Parent / Guardian Name: _____ Relationship: _____

If married: Spouse name: _____ Spouse occupation: _____

Address:_____

City: _____ State: _____ Zip: _____ Email: _____

Phones: Home _____ Work _____ Cell _____

Occupation / Grade in school: _____ Place of Employment / School: _____

Whom may we thank for referring you? _____

PSYCHIATRIC / MEDICAL HISTORY

Please list past hospitalizations for psychiatric and/or substance abuse treatment:
_____
_____
_____

Please list any previous psychiatric conditions you have been **DIAGNOSED** with in the past:
_____
_____
_____

Please list **all** current medications, dosages, etc.:
_____
_____
_____
_____

In the past, have you ever been the victim of or witnessed any type of traumatic incident? If yes, please explain:
_____
_____
_____

Are you currently under medical care for any reason? ☐YES / ☐NO (if yes, please explain):
_____
_____
_____

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Primary Care Physician Name / Phone:_____

Most Recent Psychiatrist Name / Phone:_____

Most Recent Therapist Name / Phone:_____

THIS SECTION FOR <u>FEMALES ONLY</u> (please do not leave blank)

Please check any of the following that apply:

☐ I am pregnant (or trying to become pregnant) ☐ I have had a hysterectomy

☐ I have regular menstrual periods ☐ I am perimenopausal

☐ I have never been sexually active in my life ☐ I am menopausal

☐ I have been sexually active in the past, but currently I am not sexually active

☐ I am currently sexually active, and I use the following method of birth control:

☐ I do not use any form of birth control ☐ Birth control pills

☐ My husband/other has had a vasectomy ☐ IUD

☐ Other (specify)_____

☐ I have experienced variations in mood or anxiety level related to my menstrual period

☐ I have experienced post-partum depression

CLINICAL CONCERNS

Briefly describe what prompted you to seek care from Dr. Hull at this time: _____

_____

_____

Problem Areas: In the following list, place a check mark next to each item that identifies an area of concern to you (place two checks by those items that are most important)

____ Stress / Worry
____ Anger/ Temper
____ Depression / Unhappy
____ Education / School / Work
____ Family Problems
____ Fearfulness
____ Marital Problems
____ Physical Problems
____ Problem with children
____ Religious/ Spiritual Concerns
____ Problems with Social Relationships
____ Thoughts of Suicide
____ Sexual Concerns
____ Rape
____ Incest
____ Trouble making decisions
____ Use of drugs
____ Use of alcohol
____ Other: Specify _____
_____
_____
_____

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POLICIES AND PROCEDURES

_____ Payment must be made at the time services are rendered. You may pay with check, cash, HSA/FSA card, or Credit Card (Visa, MasterCard, or Discover), or you may pay prior to your appointment online by visiting my website at www.anewstartmedicalcenter.com.
Initial

_____ The charge for a new patient appointment is $350; follow-up appointments are $100. *(you may request extended appointment times and the charges will be applied accordingly)*
Initial

_____ Because the time has been reserved for you, **PAYMENT IN FULL IS REQUIRED IF YOU FAIL TO SHOW FOR A SCHEDULED APPOINTMENT WITHOUT A 24- HOUR PRIOR NOTICE.**
Initial

_____ $30.00 charge on all returned checks.
Initial

_____ I am aware that I may not file a reimbursement claim with Medicare or Medicaid.
Initial

_____ The patient (or parent/guardian) is responsible for fees related to letters, forms, court evaluations, court preparation, court testimony, etc. The usual charge for letters and forms is $35 to $100 depending upon time and complexity.
Initial

_____ All aspects of a patient's care are confidential. The patient's records may only be released when the requesting provider obtains the patient's written permission. However, as required by law, confidentiality must be broken under the following circumstances:
Initial

1. Evidence of child or elder abuse. The law requires that the healthcare provider report this to the appropriate authorities immediately.
2. Evidence of endangerment to self or others requires that appropriate action must be taken.
3. Receipt of a court subpoena requires release of records.

_____ I am aware that Dr. Hull is not a psychiatrist, but he will be providing psychiatric medical services. He is Board Certified in Family Medicine, Clinical Lipidology, and has received a certification as a Master Clinician in Psychopharmacology by the Neuroscience Education Institute.
Initial

_____ Patient has received access to this office's Privacy Policy, and a paper copy is available upon request.
Initial

Your signature below signifies you have read, understand and agree to all of the above stated policies and procedures.

_____

PATIENT PRINTED NAME

_____ _____

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SIGNATURE OF RESPONSIBLE PARTY (relationship to patient) DATE

Adolescent Questionnaire (skip this page if you are under 10 years of or over 21 years old)

Patient Name: _____ Date of Birth: _____ Age: _____ Today's Date:_____

1. Most of all I want _____
2. I'm different from others because_____
3. People are always_____
4. It would be funny if_____
5. Girls think I_____
6. Guys think I_____
7. My family_____
8. I worry about_____
9. I wish I could stop_____
10. When I grow up_____
11. I just can't_____
12. People shouldn't_____
13. I want to know_____
14. It hurts when_____
15. If I were a boy/girl_____
16. All my life I_____
17. My father thinks I_____
18. I get mad when_____
19. When I get mad, I_____
20. If I were older_____
21. If I were younger_____
22. I'm afraid of_____
23. When I'm afraid, I_____
24. I often wonder_____
25. Other children_____
26. Nobody knows_____