Andrew C. Elgort, Ed.D., PLC

675 Peter Jefferson Parkway, Suite 130
Charlottesville, VA 22911
434.987.2759

Patient Registration

Patient Information

Name: _____ Nickname: _____

Gender: _____ Age: _____ Date of Birth: _____

Address: _____ Home Phone: _____

_____ Cell Phone: _____

_____ Work Phone: _____

Social Security No.: _____ Email: _____

Employer: _____ Occupation: _____

If patient is a minor, please complete:

Name of Parent/Guardian: _____ DOB: _____

Address: _____ Relationship to child: _____

_____ Home Phone: _____

_____ Cell Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____

Name of Parent/Guardian: _____ DOB: _____

Address: _____ Relationship to child: _____

_____ Home Phone: _____

_____ Cell Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____

Marital Status of Parents: _____ With whom does the child live? _____

Who else lives in the home?

Name	Age	Relationship	Occupation

(Use the back of this page for more people)

Financial Information

Who is responsible for payment? _____

Method of Payment: Self-Pay _____ Insurance _____

Name of Insurance: _____

Name of Policy Holder: _____ Date of Birth: _____

Social Security No. of Policy Holder: _____ Relationship to patient: _____

Insurance No.: _____ Group Number: _____

Employed by: _____

Authorization and Release: I hereby authorize and request my insurance company to pay my insurance benefits directly to *Andrew C. Elgort, Ed.D., PLC*, for services rendered. I authorize the release of any information required by my insurance company to file for these benefits. I agree to be responsible for payment for all charges not covered by my insurance company

_____ _____

Signature of Patient or Parent/Guardian of Minor Date

Patient Questionnaire

1. Why are you seeking services? _____

_____

_____

_____

2. Have you (or your child) ever received counseling services before? If so, where and with whom? _____

_____

_____

3. Have you (or your child) ever been on medication for a mental health problem? If so, what were you prescribed? By Whom? How long did you take the medication? _____

4. Have you (or your child) ever been hospitalized for a mental health problem? _____

5. Have others in your family experienced mental health problems? _____

Medical History

Primary Care Physician: _____

Address/Phone No.: _____

1. Do you (or your child) have any current medical problems for which you are receiving treatment? _____

2. Do you (or your child) have any chronic medical problems for which you are receiving on-going treatment? _____

Current medications/dosages: _____

3. Have you (or your child) ever lost consciousness, sustained a head injury, had a seizure, undergone an operation? If so, what was the issue? When did it happen? How did it resolve?

4. Do you (or your child) smoke? Use/abuse alcohol or drugs? _____

5. For Children: Did your child meet his/her developmental milestones within expected timeframes? Were there issues during the pregnancy or immediately after the birth? _____

Personal History

Education:

For Adults: Highest degree/grade completed? _____

School: _____

For Children: Current School? _____

Grade: _____ Teacher: _____

Has your child ever been evaluated for learning or behavioral difficulties by the school? If yes, when? What was the outcome? _____

Has your child ever received special education? Has your child ever repeated a grade? If yes, when? _____

Spiritual Life:

How important is spirituality/religion in your life? ____Very ____Somewhat ____ Not important

Denomination _____ Church/Synagogue _____

Other information:

Have you (or your child) ever been involved with the police? Social services? Court system? If so, under what circumstances? How did it resolve? _____

_____

What stressors are you (or your child) facing now or have faced within the last year (e.g., divorce, death of family member, bullying, etc.)? _____

_____

_____

_____

Is there any other information you need think it is important to be shared? _____

_____

_____

_____

Privacy Acknowledgement

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I have been given the opportunity to receive, review, and discuss the Notice of Privacy Practices for the mental health practice of Andrew C. Elgort, Ed.D., PLC.

_____ _____

Signature of Patient or Parent/Guardian of Minor Date

_____ _____

Relationship to patient Name of minor patient