James Nalbone, MD
4 Executive Park Drive Albany, NY
518 438 - 9722

PATIENT REGISTRATION AND SELF-ASSESSMENT FORM

Name		**Date**
Date of birth (month/day /year)	**Age**	
Street	**Suite/Apt. #**	
City	**State, ZIP**	
Phone (home) ☐ **Check here if you would prefer NOT to be contacted at this number**	**Phone (work)** ☐ **Check here if you would prefer NOT to be contacted at this number**	
Cell ☐**Check here if you would prefer NOT to be contacted at this number**		
Name of person to call in an emergency		**Relationship**
Street		**Suite/Apt. #**
City	**State**	**ZIP code**
Phone		
Name of person filling out this form (if not patient)		
Name of Primary Care Physician (PCP):		**Date last seen:**
PCP Office Address:		**Suite/Apt. #**
City	**State**	**ZIP code**
Phone #:	**Fax#**	

Insurance Information:

Insurance Company	**Ins. Phone**
Subscriber	**ID #**
Subscriber's Employer	**Birth Date**
Patient's relationship to subscriber	
Secondary Insurance Company	**ID#**

Statement of Release by Patient to Insurance Company

I request that payment of authorized insurance benefits be made on my behalf to James Nalbone, MD for services furnished to me by this practitioner. I authorize James Nalbone, MD to release medical information about me to the applicable insurance company should any information be needed to determine these benefits. Please be advised that only the minimum necessary information will be disclosed to serve these administrative purposes.

I understand that I am responsible for any unpaid balances not covered by my insurance, and that all co-pays and/or deductibles are due on the day of service.

I understand that I will be charged $75.00 for any missed pharmacological management appointment (15-20 minutes in length) and $125 for any missed psychotherapy appointment (45 minutes in length) without 24-hour notice.

I have reviewed and acknowledge the above cancellation and co-payment policies:

Initial:_____

I acknowledge that the above information I have provided is correct. I agree with the payment obligations as outlined above.

_____ _____

Patient Signature Date

Reason for Consultation: **Please describe the reason you are requesting a consultation or treatment.**

_____

_____

_____

_____

_____

_____ If necessary, use another sheet of paper.

History of Problem: **Please describe your condition from your symptom onset to the present. Provide as many details as possible regarding past symptom and treatment history.**

_____

_____

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_____

_____ If necessary, use another sheet of paper.

Family Psychiatric History: **Please list any relatives of whom you are aware who have had psychiatric problems, please include as many details as possible.** _____

_____

_____

_____ If necessary, use another sheet of paper.

Medical History

Age when first occurred	List all past and present medical problems as well as any surgery or accidents.

Current Medications and Dosages

Allergies
(Be sure to include medication allergies)

Drinking (Alcohol Use)

In an average two week period, how many days do you consume at least one drink?

Check if you ever felt that you were, or someone told you that you were, drinking too much? ❑

If "yes," please explain:

Drugs of Abuse
Check if you have taken any of the following drugs.

- none ❑
- marijuana ❑
- amphetamines/speed ❑
- heroin/opiates ❑
- PCP ❑
- LSD/hallucinogens ❑
- cocaine/crack ❑
- barbiturates/sedatives/downers ❑

Have you used any of these substances in the last year? ❑

If "yes," please list how often:

Additional Information:

Weight and Height

Current weight:

Check if your weight has increased or decreased by more than 10 pounds during the last 5 years. ❑

If yes, explain reason:

Current height:

I acknowledge that the above information is complete and accurate to the best of my knowledge. Also, should any of this information change, I will notify James Nalbone, MD, as soon as possible.

_____ _____
Patient Signature Date

Reviewed by James Nalbone, MD:

_____ _____
Date