best day PSYCHIATRY AND COUNSELING, PC

1. **Please select your desired office location**

- ○ Fayetteville
- ○ Fuquay-Varina
- ○ Durham
- ○ Charlotte
- ○ Winston-Salem
- ○ Raleigh
- ○ Greenville
- ○ Wilmington
- ○ Greensboro

2. **Are you inquiring about services for yourself or for a loved one?**

- ○ I am interested in services for myself
- ○ I am filling this out on someone's behalf

Contact Person

3. **Please enter YOUR information**

Name ______________________ Relationship to patient ______________________

Phone Number ______________________ E-mail ______________________

4. **If applicable please list legal guardian of patient. Legal documentation must be provided to be kept on file. This includes adoptive parents, step parents, grandparents, foster parent incompetent persons or any situations of custody**

____

____

____

____

New Client Information

5. **Patient information**

First Name: __________ Last Name: __________ Date of Birth: __________ Gender Identity __________

Address: ______________________ Zip Code __________

Preferred Phone __________ May we leave a confidential voicemail? ○ Yes ○ No

Email __________ Is it okay to email you? ○ Yes ○ No

6. How did you hear about us?
   - My doctor or therapist referred me
   - I found Best Day on my own
   - A friend recommended you!

7. Name of referring provider:

   ____

8. What brings you to seek services at this time?

   ____

9. What service are you currently seeking?
   - Medication Management
   - Therapy
   - Both

Screening Questions

10. Are there any handicap issues? If so, please specify so we can make any necessary accommodations.

    ____
    ____
    ____
    ____

11. Can the patient climb stairs?
    - Yes
    - No

12. Do you have any religious preferences?

    ____

13. Are you currently having any suicidal or homicidal ideations? We are not a crisis walk in clinic. If you are having thoughts or harming yourself or others please call 911 or visit your closest emergency room.
    - Yes
    - No

14. Any past issues with suicide?

    ____
    ____
    ____
    ____

15. Have you had a mental health evaluation in the past 6 months?

- Yes
- No

16. Are there any hallucinations?

- Yes
- No

17. Any issues with violence?

- Yes
- No

18. Please elaborate

____

Insurance Information

19. Do you have insurance?

- Yes!
- No, I am self pay

20. Please enter information found on your insurance card (make sure to include all letters and numbers)

Insurance Carrier	ID Number
Group Number	Insurance Customer Service Number
Subscriber Name	Subscriber DOB
Patient's Name (As stated on Insurance Card)	

21. Do you have secondary insurance?

- Yes
- No

22. Please enter information found on your insurance card

Insurance Carrier	ID Number
Group Number	Insurance Customer Service Number

All done! Please don't forget to hit "submit form" at the bottom of the page.

Thank you for filling out the intake form! Please allow 24-48 hours for processing and one of our wellness coordinators will contact you to schedule your initial appointment.

Be sure to return here to complete the Patient History Form prior to your scheduled appointment.

Thank you for choosing Best Day Psychiatry & Counseling!