JOHN J. BENJAMIN DAVIDMAN
560 BROADWAY, SUITE 510
NEW YORK, NY 10012

NEW PATIENT FORM

Please print this page and complete as much as you can before your first appointment.

____

NAME (LAST, FIRST, M.I.) **BIRTH DATE**

____

STREET ADDRESS **CITY** **STATE/ZIP**

____

HOME PHONE **WORK PHONE** **CELL PHONE**

Please circle which phone you would prefer I call first.

EMAIL ADDRESS:____

In case of an emergency, is there someone I can contact? If Yes, list below:

____

NAME **PHONE** **RELATIONSHIP**

INSURANCE INFO

This is for my records only. You are responsible for submitting your claims to the insurance company.

____

NAME OF POLICY HOLDER **ID#** **EMPLOYER'S NAME**

____

INSURANCE PLAN NAME **IS THIS YOUR ONLY PLAN?**

Enter the policy holder's information, including birth date:

ADDRESS CITY STATE/ZIP

PHONE BIRTH DATE RELATIONSHIP TO YOU

MEDICAL INFORMATION

What is your primary care physician's name and phone number?

When was your last physical?

Do you have any allergies to medications? Yes No Which ones?

What medical problems do you have?

What surgeries have you had?

How often do you drink alcohol? How much do you drink at a time?

Do you use drugs, or smoke cigarettes? If so, how much/how often do you use?

Do any relatives have psychiatric illnesses?

Are you currently taking birth control? Yes No

Are you currently pregnant, breast-feeding or considering pregnancy? Yes No N/A

Below, please list all of the medications you are currently taking, including over-the-counter, vitamins, herbs, etc.

NAME	DOSE	WHEN DID YOU START/STOP IT?

PAST TREATMENT

List the name and contact information for any therapists or doctors you currently see for treatment, as well as any psychiatrists, therapists or hospitals where you have previously received psychiatric care. If you plan on having your records released, click here for a form you can send past providers or call them to request your records be transferred.

NAME AND TYPE OF TREATMENT	ADDRESS	PHONE/FAX