Joseph Bryer, M.D.

NEW PATIENT INFORMATION

(Please PRINT a Copy, then Complete)

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work/Cell Phone: _____

If necessary, may we call you at work? Yes____ No____

Age: _____ Marital Status: _____ Number of Children:_____

Social Security Number: _____ Birthdate: _____

Occupation_____

Primary Insurance Carrier_____ Policy Number_____

Subscriber(if different from patient):_____Group #_____

Secondary Insurance Carrier_____ Policy Number_____

Subscriber(if different from patient):_____Group #_____

MEDICAL HISTORY

Which of the following medical conditions do you have now or have you had in the past:

☐High blood pressure	☐ Diabetes	☐Heart attack/angina
☐Stroke	☐Asthma	☐Thyroid gland disease
☐Head injury with loss of consciousness	☐Seizures or epilepsy	☐Stomach ulcer
☐Cancer (specify type)	☐Liver disease	☐Kidney disease
☐Multiple sclerosis	☐Glaucoma	☐Parkinson's disease
☐ Irritable bowel syndrome	☐Ulcerative colitis/Crohn's	☐Emphysema

☐Other Significant Medical Conditions? _____

Allergic to any medications?: ☐No ☐Yes, Specify_____

Have you ever been under the care of a psychiatrist? ☐ No ☐Yes

Have you ever been admitted to a psychiatric hospital? ☐ No ☐Yes

Have you ever done anything to intentionally harm yourself? ☐ No ☐Yes

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Have you ever done anything to cause physical harm to others? ☐ No ☐Yes

Primary Medical Doctor:_____ Referred to me by whom?:_____

Current Medications:_____
_____
_____
_____

Emergency Contact (Name and Phone Number):_____

Any Additional Comments/Information?:_____