NEW [TELEMEDICINE] PATIENT REQUIRED INFORMATION

BEVERLY G CLEFF, ED.D, APRN

Ph: 775- 870-9394 eMail: drbcleff@gmail.com Fax: 775-453-9748

[Completing and submitting this information also signifies that you are consenting to telemedicine sessions only during the pandemic restrictions and in person sessions when restrictions are lifted]

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_APT#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIPCODE\_\_\_\_\_\_\_\_\_\_\_\_\_

BEST PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OTHER PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS //S //M //DIV //OTHER

EMAIL ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OCCUPATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE MD\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_MD PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHARMACY NAME AND LOCATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INSUREDS ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_

EMERGENCY CONTACT NAME, RELATIONSHIP, PHONE#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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WHAT PRESCRIPTION MEDICATIONS DO YOU CURRENTLY TAKE: [NAME, DOSE]

ANY MEDICATION ALLERGIES:

ANY HOSPITALIZATIONS FOR MEDICAL, SURGICAL OR MENTAL HEALTH PROBLEMS:

 YES NO

ANY OF YOUR BLOOD RELATIVES HAVE PROBLEMS WITH DRUGS, ALCOHOL, OR MENTAL HEALTH?

 YES NO

DO YOU SMOKE: WHEN DID YOU QUIT:

HOW MUCH CAFFEINE DO YOU USE DAILY:

HOW MUCH ALCOHOL DO YOU DRINK IN A WEEK:

OFTEN DRINK TO DRUNKENESS: Y N TO BLACKOUT: Y N ANY DUI Y N

EVER TRY ANY STREET DRUGS: Y N WHICH:

LAST USE OF STREET DRUGS:

**PLEASE CIRCLE ANY OF THESE SYMPTOMS THAT ARE CURRENTLY BOTHERING YOU**:

|  |  |  |
| --- | --- | --- |
| SLEEP  | ANGER | CONCENTRATION/FOCUS |
| RESTLESSNESS | MEMORY | BEING OVERWHELMED |
| HOPELESSNESS | IRRITABILITY | EMOTIONALLY FLAT |
| APPETITE | TEARINESS | WORRIED |
| MOTIVATION | ANXIETY/PANIC | SUICIDAL THOUGHTS |
| ADDICTION | WEARY | SOMETHING ELSE |

INFORMATION SPECIFIC TO TELEMEDICINE RESTRICTIONS ONLY:

After you download and complete these forms, please save them on your computer as either a Word document or a PDF. You will also need a copy of your insurance card, or a written copy of all of the information on the card front saved as a document or PDF. At our first session, I will be able to get these files from you using my telemedicine program.

In order to begin a session, I will send you an email with a link to my “waiting room” a few minutes before the scheduled time. You will need to use a computer browser [Chrome or Foxfire work well] or any electronic that has a microphone or camera available. The program [doxy.me] is secure, no data is saved on it except your email address, and it meets all requirements for telemedicine security. By clicking on the link to start the session you are also agreeing to the use of telemedicine during the pandemic.