BRIDGEPOINT

Arun K. Kantamneni, MD, Psychiatrist
Darshan A. Patel, MD, Psychiatrist

NEW PATIENT FORM

PATIENT DEMOGRAPHICS:

Name (First, MI, Last):_____ DOB: _____ Gender: ____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email:_____

INSURANCE (Primary):

Company Name: _____ ID #:_____ Phone #: _____

(Secondary):

Company Name: _____ ID #:_____ Phone #: _____

EMAIL ID AND INSURANCE CARDS TO bridgepointclinic@outlook.com

VISIT INFORMATION

Reason for Visit/Current Diagnosis: _____

Primary Care or Referring Doctor: _____ Phone #:_____

Family Members at home: (Spouse, Parents, Children, Siblings, Other) _____

_____

Current Medical Illnesses: _____

Medication Allergies:_____

Current Pharmacy: _____

List all **CURRENT** medications: (include dosage and frequency): _____

_____

List all **PRIOR** Psychiatric medications: (include dosage and frequency): _____

_____

Prior Psychiatric History: (Inpatient Admission, Previous Providers, Prior Dx, Testing, Etc...)

_____

SIGNATURE ACKNOWLEDGEMENT

Your signature acts as a comprehensive signature acknowledgement for the following forms and policies. These forms have been sent to you through the patient portal, are available on the website, and can be printed for you at your request. You further acknowledge that you have read, understand, and accept each policy in its entirety.

HIPAA Form • Controlled Substance Agreement • Payment Policy • Treatment Consent

Signature: _____ Print Name: _____ Date: _____

p: 770-858-5377 | f: 770-874-3310
4125 Atlanta Road SE, Suite 120 | Smyrna, GA 30080