focus | APPOINTMENT REQUEST FORM

I would like to schedule a new patient appointment for a child (age) _____
I would like to schedule a new patient appointment for an adolescent (age) _____
I would like to schedule a new patient appointment for an adult (age) _____

Does patient have a previous ADHD diagnosis?	Yes _____	No _____
If yes, does patient have documentation of diagnosis?	Yes _____	No _____
If yes, has the documented testing been done within the last three years?	Yes _____	No _____
Is patient currently under a physician's care for treatment of ADHD?	Yes _____	No _____
If yes, is patient taking medication for treatment of ADHD?	Yes _____	No _____

PATIENT INFORMATION

First _____ Middle _____ Last Name _____
Nickname (if applicable) _____ Date of Birth _____ Male☐ Female☐
Patient Mailing Address _____ City _____ St ____ Zip _____
Patient Cell Phone (if applicable) _____ Patient Home Phone _____
Work Phone (if applicable) _____ Preferred Method of Contact _____
Patient Email Address (if applicable) _____

PARENT/SPOUSE INFORMATION (IF APPLICABLE)

Name of Mother/Father or Legal Guardian _____ Cell # _____
Relationship to patient _____ Is Mailing Address same as patient address ? _____ If no, please note below _____
Mailing Address _____ City _____ St ____ Zip _____
Email Address of individual above _____
Is the above listed parent/guardian responsible for patient account? _____
If no, please list responsible party along with insurance information in the insurance section below. _____

PATIENT CONSENT (IF OVER THE AGE OF 18)

I give Focus my consent to contact the individual(s) above should additional information be required to scheduled my appointment.

Signature of Patient _____ Date _____

INSURANCE INFORMATION

Insurance Carrier _____ Contract # _____ Group # _____
Policy Holder's Name on Card _____ Policy Holder's Date of Birth _____
Policy Holder's Mailing Address if different than above _____
Responsible Party (yes) _____ (no) _____ Relationship to Patient _____ Cell # _____
If no, please name responsible party _____ Cell # _____
Refer to the back of your insurance card for the phone # for Provider Benefits/Eligibility (___) _____

Name of Referring Medical Professional : (If applicable – referral not required to schedule an appointment)
Name _____ Phone _____ City _____ St ____ Zip _____

PLEASE FAX/SCAN OR EMAIL COMPLETED FORM TO YOUR LOCAL FOCUS OFFICE