



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 _____

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