Nat Kuhn MD
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New Patient Information

Date: ___ /___ /_____

Name	First		MI	Last			
Address						Apt #	
City				State		Zip	
Sex	☐ Male ☐ Female		Birth Date	___ /___ /_____	SSN	- -	
Marital Status	☐ Single ☐ Married ☐ Same-Sex Union ☐ Separated ☐ Divorced ☐ Widowed						
Emergency Contact	Name			Relationship	Phone ( ) -		

Contact Information

E-Mail (optional)	Email address	
	☐ Please send e-mail reminders 48 hours before appointments ☐ Please enroll me in the secure patient portal, which allows me to view and pay bills on line, and allows for secure messaging (recommended)	
Preferred Phone	( ) -	☐ Mobile ☐ Home ☐ Work ☐ OK to leave messages ☐ Please send text reminders 24 hours before appointments
Other Phone	( ) -	☐ Mobile ☐ Home ☐ Work ☐ OK to leave messages ☐ Please send text reminders 24 hours before appointments

Employment/School Information

Employment	☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Student ☐ Disabled				
Employer or School	Name				
	Address				
City		State		Zip	

Insurance Information: Primary Insurance (if you are using insurance)

Insurance Name	Name		Address				
City		State		Zip		Phone	( ) -
Subscriber ID		Group #		Policy #			
Subscriber Name	"Same" if same as patient						
Subscriber Address	City, State, Zip; "Same" if same as patient						
Sex	☐ M ☐ F	DOB	___ /___ /_____	Relation to Pt		Co-Pay	

Patient's Name	Please print

Insurance Information: Secondary Insurance (if you are using secondary insurance)

Insurance Name	Name	Address					
City		State		Zip		Phone	( ) -
Subscriber ID		Group #		Policy #			
Subscriber Name	"Same" if same as patient						
Subscriber Address	City, State, Zip; "Same" if same as patient						
Sex	☐ M ☐ F	DOB	___ /___ /_____	Relation to Pt		Co-Pay	

Billing Method

Choose only one	☐ Please send statements via e-mail ☐ Please send statements via the secure portal (recommended) ☐ Please send statements via US mail

Financially Responsible Party (Who is responsible for balances? Write "same" if same as patient.)

Name	First	MI	Last		
Address				Apt #	
City		State		Zip	

Patient (or Guardian): Read, sign, and date all sections

Release of Information	I authorize Nathaniel S. Kuhn, MD to release any medical or other information necessary to process insurance claims to his billing service and to the insurance companies and/or case management organizations that are providing my mental health insurance. I also request payment of government benefits either to myself or to the party who accepts assignment below.	
	Signed: _____	Date: _____
Assignment of Benefits	I authorize payment of all medical benefits directly to Nathaniel S. Kuhn, MD.	
	Signed: _____	Date: _____
Patient's Responsibility for Payment	I understand that I am responsible for payment for services that are not covered by my insurance plan for whatever reason, including denial of medical necessity, late cancellations, missed appointments, same day/same charge duplication by different providers, etc.	
	Signed: _____	Date: _____
Security of E-Mail	I consent to email communication, understanding that it cannot be guaranteed to be 100% secure. I understand that this is optional.	
	Signed: _____	Date: _____

Patient's Name	Please print

Additional Information

Who is your primary care provider? Please give name, location, and phone number.

Please briefly describe any current medical problems or significant medical history

Please list all medications and supplements you are currently taking

Please list all medication allergies you have, specifying what reaction you have and how severe it is

Please list any current prescribers other than your primary-care provider, giving names, locations, and phone numbers

Patient's Name	Please print

Please briefly describe any previous therapy, counseling, or treatment with psychiatric medications

Please describe any alcohol and/or drug use

If you have had suicidal thinking, suicide attempts, any psychiatric hospitalizations, or any thoughts/impulses/history of harming others, please describe briefly

Is there anything else you would like me to know?