DENT NEUROLOGIC INSTITUTE

716.250.2000 | dentinstitute.com

Amherst | 3980 Sheridan Drive • Amherst, NY 14226
Orchard Park | 200 Sterling Drive • Orchard Park, NY 14127

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

★ **Documents:** You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS. If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.

★ **Insurance Card:** You must provide us with your insurance card.

★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan $200 is required at the time of service; any remaining responsibility will be billed to you.

★ **Identification:** You must provide us with photo ID or two other forms of identification.

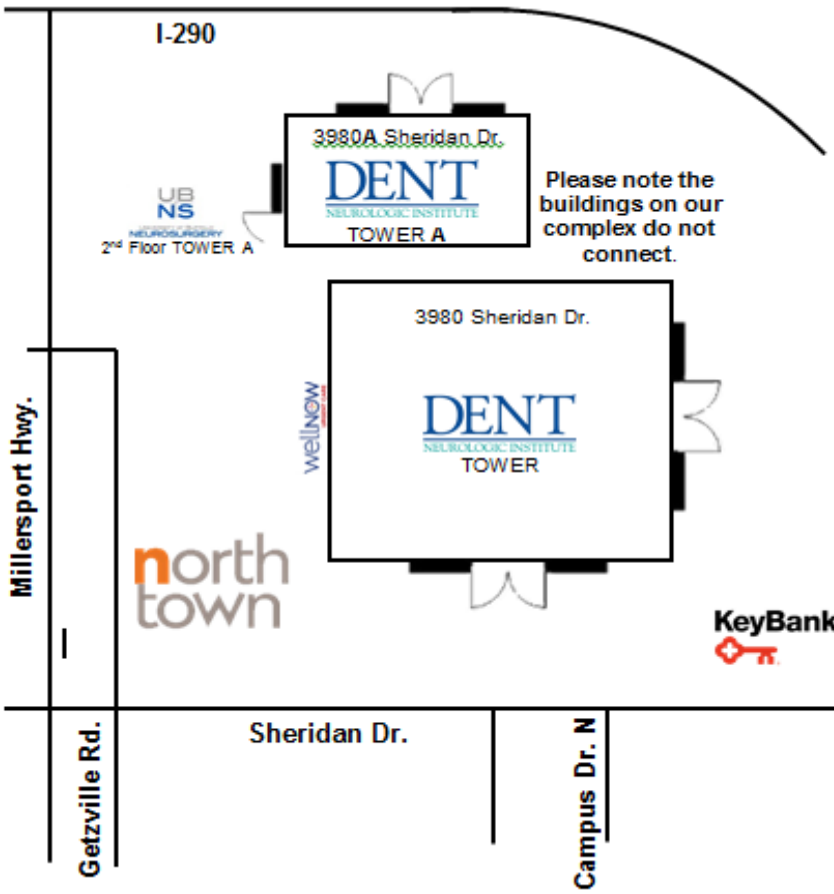
★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit.

Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.



DENT
NEUROLOGIC INSTITUTE

Amherst Location

3980 Sheridan Drive
Amherst, New York 14226

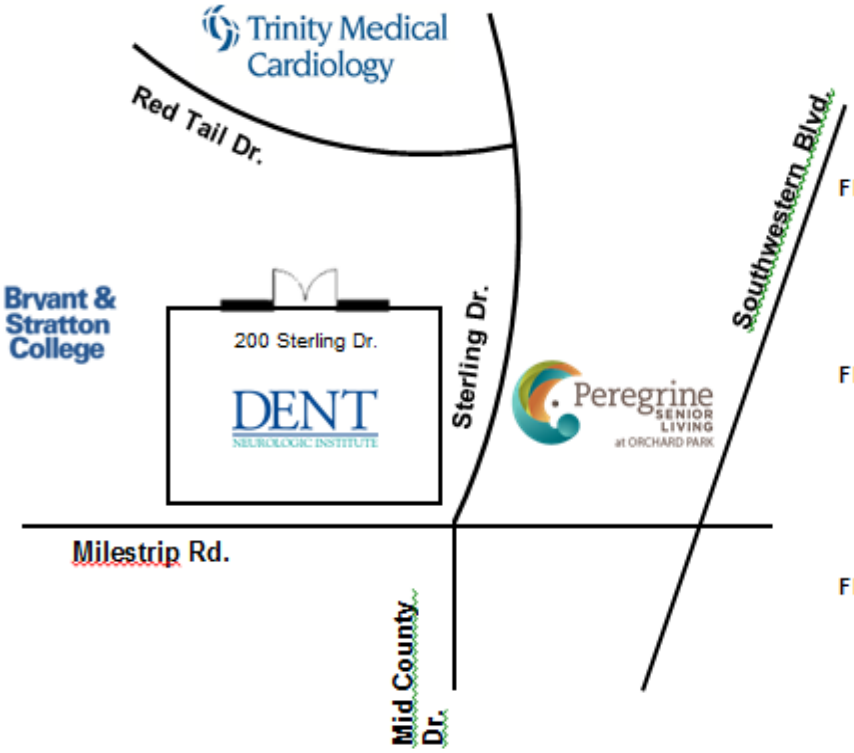
DRIVING DIRECTIONS:

FROM NIAGARA FALLS/NORTHTOWNS

- Robert Moses Parkway South
- I-190 South
- I-290 East
  (Youngman Exp/Exit 16 towards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTHTOWNS

- I-190 East
- Merge into I-290
  (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower



Orchard Park Location

200 Sterling Drive
Orchard Park, NY 14127

DRIVING DIRECTIONS:

FROM SOUTHTOWNS

- Route 219 N to Milestrip Road East
  (1st Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM BUFFALO

- Thruway (90) West to Route 219
- Exit Milestrip Road East
  (2nd Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM PENNSYLVANIA

- Thruway (90) East to Exit 56
- Left onto Milestrip Road
- Left onto Sterling Drive
- Left on Red Tail
- Left into parking lot

DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:							
PATIENT INFORMATION							
Last Name:	**Middle:**	**First:**	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital Status (circle one):** Single / Mar / Div / Sep / Wid		
Former Name:		**Birth Date:**	**Age:**	**Sex:** ❑ M ❑ F	**Transgender:** ❑ T		
Street Address or P.O. Box:		**E-mail Address:**		**Home Phone: ( )** Cell Phone: ( )			
City:	**State:**	**Zip Code:**		**Social Security Number:**			
Referring Physician:		**Primary Physician:**					
Occupation:	**Employer:**			**Employer Phone: ( )** ❑ Full Time ❑ Part Time			
Race:	**Ethnicity:**			**Language:**			
Pharmacy Name:	**Pharmacy Address:**			**Pharmacy Phone:**			
CONTACT PERSON IN CASE OF EMERGENCY							
Name:	**Relationship:**	**Home Phone: ( )**	**Work Phone: ( )**				
INSURANCE INFORMATION							
You will need to give your insurance card to the receptionist							
Person Responsible for Bill (if not self):	**Address (if different):**			**Home Phone: ( )** Cell Phone: ( )			
Birth Date: / /	**Occupation:**						
Responsible Party's Employer:	**Employer Address:**			**Employer Phone: ( )**			
PRIMARY INSURANCE	**Insurance Plan:**						
Policy No:		**Group No:**					
Subscriber's Name (if not self):	**Subscriber's SSN:**			**Co-pay Amount:**			
	Subscribers DOB: / /						
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other			
SECONDARY INSURANCE	**Insurance Plan:**						
Policy No:		**Group No:**					
Subscriber's Name (if not self):	**Subscriber's SSN:**						
	Subscribers DOB: / /						
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other			

IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU <u>MUST</u> COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from $75 - $200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus - Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

PLEASE REVIEW AND SIGN OUR PRACTICE POLICIES

Insurance Information/Assignment of Benefits…… Patients are required to provide DENT with current and accurate insurance information at every visit. Your **FAILURE** to provide us with accurate information will result in a patient bill that you may be held responsible for. By signing below, you authorize DENT to furnish information to insurance carriers concerning your illnesses and treatments and hereby assign all payments for medical services rendered to you or your dependents to Dent Neurologic. Furthermore, you will be held responsible for any amount not covered by your insurance plan.

Co-Pay, Deductibles, POS Plans, Private Payments and Unpaid Balances…… In accordance with the provision of your insurance plan, you may be required to pay for a portion or all of your medical services. As a result, if you have a co-pay, deductible, or Point of Service Plan or you are a private paying patient, **payment is required at the time of service.** Should you need to discuss this payment policy, you may contact our Business Office at 250-2010 prior to your appointment. Please note it is within our discretion to take current payments and apply them to existing unpaid balances or move credit balances to future appointments. If for any reason, you maintain an unpaid balance on your account and fail to work out a payment arrangement with us, after 90 days your account will be turned over to a collection agency, proceedings will begin and you will be discharged from our care. Accounts sent to collections will have a 30% collection fee added to the balance along with applicable attorney fees.

Identity Theft…… The Federal Trade Commissions, "Red Flag" rule requires health care providers to establish a program to prevent identity theft. As a result we will be asking all patients to provide photo identification when checking in for their appointment and will be taking a photograph to be used for the sole purpose of identification. If you are unable to provide us with proper identification at the time of your visit, we will need to **RESCHEDULE** your appointment.

Practice Communication Information…….. Patients in our practice may be contacted via phone, email, and/or text messaging to remind of appointments, payment, treatment, and/or other healthcare information. By entering information below, you consent to receiving these communications from us:

Send reminders/information (*select all that apply*):	☐ Voice ( ) -		
	☐ SMS/text ( ) -		
	☐ E-mail address: _____ *Note: reminders not available via e-mail*		
Preferred Phone Number (**select one**):	☐ Home	☐ Cell	☐ Work
Preferred Language (**select one**):	☐ English	☐ Spanish	
Best time to contact me (**select one**):	☐ Morning	☐ Afternoon	☐ Evening
☐ I do NOT wish to receive any reminders or communications from Dent as outlined above. I understand the cancellation and no show policy as outlined below.			

Medical Photography…….. Medical photography taken for diagnostic purposes will become a part of your medical record and remain confidential in accordance with regulatory requirements and Dent Policy. From time to time we may use de-identified medical imaging or photography for research or academic purposes. Dent retains all ownership rights in these programs.

Prescription Refills……..…… Patients must contact their pharmacies to request any prescription refills for medications that DENT prescribes. In turn, the individual pharmacies will contact our organization with those requests. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.

Appointment Cancellation and No Show Policy…… Your scheduled appointment is time reserved especially for you. **We require a minimum of 24-hours advance notice for cancellation or rescheduling of an appointment to allow us to offer this time to other patients**. Rescheduling fees are: $100-Imaging, VNG, Neuropsychology, Sleep Studies. $50-All other appointments.

General Consent to Treatment and Right to Refuse Treatment..… By signing below, I (or my authorized representative on my behalf) authorize DENT Neurologic Institute and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

In giving my consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

I have read and agree to all of the above policies. I understand that my failure to comply with any of these policies may result in discharge from the medical practice.

Print Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Statement of Financial Responsibility

Insurance Coverage.* The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of DENT fees. You are ultimately responsible for payment of your bill.

Due to the increasing complexity of insurance plans, DENT requires you to contact your insurer's Member Services for information on your coverage and out-of-pocket costs. For some services, DENT will collect a fee from you before the service is rendered. That amount will be credited against the cost of that service, but in many cases will not cover the full amount. Your insurance plan is the best place to find information on the ultimate cost to you.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. DENT expects these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved service period, you will be responsible for your balance in full.

Your signature below will also authorize your insurer to pay any benefits directly to DENT, the full and entire amount of the bill incurred by you or the named patient, or if applicable, any amount due after payment has been made by your insurance carrier.

Co-Pay Policy. It is expected that patients will pay co-pays at the time the service is rendered for each visit, typically during check-in.

Cancellation / No Show Policy. DENT understands there may be times when you miss an appointment due to emergencies or other obligations. However, patients who fail to provide adequate cancellation notice, at least 24 hours prior to the appointment time will be assessed a $50 reschedule fee (NOTE: $100 for Sleep Center, Neuropsychology testing and VNG testing appointments). All assessed fees are collected at the time of scheduling the next appointment. Patients will not be able to reschedule an appointment until all fees are paid.

By signing below, you acknowledge that you have read the above policies regarding financial responsibility to DENT for providing health care services to you or the named patient and that you understand and agree to the terms described.

Patient Name (please print): _____ DOB: _____

Patient or Guardian Signature: _____ Date: _____

*Patients with No Fault or Workers Compensation coverage will be handled in compliance with New York State law with regard to payment and benefits.

DENT NEUROLOGIC INSTITUTE
WORKERS COMPENSATION
SUPPLEMENTAL INFORMATION FORM

Today's Date:	Date of Birth:	
Patient Name:	Social Security No:	
Date of Injury:		
Employer Name:	Employer Address:	
Employer Phone Number: ( )	Your Job Title:	Are you out of work due to this injury: ❑ Yes ❑ No

COMPENSATION INSURANCE CARRIER INFORMATION

Insurance Carrier Name:	Insurance Carrier Address:
Carrier Claim Number:	WCB Case Number:
Name of Case Manager:	Phone: ( )
	Fax: ( )
Briefly Describe the Injury you Sustained:	
Briefly Describe how Injury Occurred:	

ATTORNEY INFORMATION

Attorney Name:	Attorney Address:
Phone: ( )	Fax: ( )

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:	Date of Birth: Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: ❑ Yes ❑ No
Injury Sustained:	
INSURANCE CARRIER INFORMATION	
Insurance Carrier Name:	Insurance Carrier Address:
Name of Adjuster:	Claim Number:
Phone: ( )	Fax: ( )
ACCIDENT DETAILS	
Location of Accident:	
Briefly Describe how the Accident Occurred:	
Were you a: ❑ Driver ❑ Passenger ❑ Pedestrian	
If Driver or Passenger, were you: ❑ Belted ❑ Not-Belted	
Have you Filed a Claim with your Carrier: ❑ Yes ❑ No	Have you Completed and Returned your No-Fault Application: ❑ Yes ❑ No
ATTORNEY INFORMATION	
Attorney Name:	Attorney Address:
Phone: ( ) Fax: ( )	
Signature:	**Date:**

FOR OFFICE USE ONLY

PROVIDER: **DENT NEUROLOGIC GROUP** **PO Box 8000 Dept 057** **Buffalo, NY 14267** **Signature: _____**	**CLAIM# _____** **DATE OF LOSS: _____** **CARRIER: _____**

Today's Date:

For Office Use Only
MDQ: _____PHQ-9:_____ **GAD-7**: _____

1. General Information:

Name: _____ Sex: M / F Date of Birth: _____ Age: _____

SS #: _____ Marital Status: Single/Married/Separated/Divorced/Widowed
Name of Referring Physician: _____ Phone #: _____
Name of Primary Care Physician: _____ Phone #: _____
Name of Therapist/Counselor: _____ Phone #: _____

2. Problem: Please write the reason(s) you are seeing a psychiatrist:

_____
_____
_____
_____
_____

Do you have problems with sleep? □ Yes □ No
If so, what are they? (M*ark all that apply*)

□ Can't fall asleep □ Interrupted sleep □ Wake up tired □ Sleep too much
□ Legs moving □ Snoring □ Nightmares

Do you have problems with any of the following? (M*ark all that apply*)

□ Appetite □ Memory □ Level of energy □ Anxiety/Worry
□ Panic □ Staying focused □ Distractibility □ Irritability
□ Impulsiveness □ Racing thoughts

Please list all medications you are <u>currently taking</u> with dosages: (include vitamins/supplements)

Name of Medication:	***Dose (How much do you take):***	***Frequency (When do you take):***

3. MEDICAL HISTORY:

Height: _____ft. _____ in. Weight: _____ lb. □ Left-handed □ Right-handed

Do you have any of the following medical conditions?

❑ Diabetes	□ High blood pressure□	□ Heart disease	□ Migraines
❑ Thyroid problems	□ Seizures/Epilepsy	□ IBS/IBD	□ Fibromyalgia
❑ Chronic Fatigue	□ Chronic Pain	□ Back injury	□ Osteoporosis
❑ Rheumatoid arthritis	□ Hypogonadism	□ Liver disease	□ Head injury

If yes to head injury, any loss of consciousness? □ Yes □ No
Longer than five minutes? □ Yes □ No
Have you ever had a DEXA scan? □ Yes □ No
Have you ever been on oral steroids for more than 3 months? □ Yes □ No
Have you ever been on an enzyme-inducing anticonvulsant? □ Yes □ No

Please list any additional medical conditions: _____
_____
_____

Do you have any allergies or known drug allergies? □ Yes □ No
If yes, please list and include your reaction(s): _____
_____
_____

Please list any hospitalizations and/or surgeries: _____
_____
_____

FOR WOMEN: Date of your last period: _____
Are you currently pregnant or trying to become pregnant? □ Yes □ No
Are you currently breastfeeding? □ Yes □ No
Are you currently on birth control? □ Yes □ No
Are you currently on hormone replacement therapy? □ Yes □ No

4. PRIOR PSYCHIATRIC HISTORY:

Have you ever seen a: (*mark all that apply*)
□ Psychiatrist □ Psychologist □ Therapist □ Counselor
If so, please list who and when:
Name: _____ Dates: _____
Name: _____ Dates: _____
Name: _____ Dates: _____
Additional names: _____

Have you ever been hospitalized for a psychiatric disorder? □ Yes □ No
If so, please list where and when:
Facility: _____ Dates: _____
Facility: _____ Dates: _____
Facility: _____ Dates: _____
Additional information: _____
_____
_____
_____

Name: _____ DOB:_____

5. PRIOR PSYCHIATRIC HISTORY(Continued):

Have you ever tried to hurt yourself or others? □ Yes □ No

If so, please list who and when:

_____

_____

_____

6. FAMILY PSYCHIATRIC HISTORY:

Please describe any family history of psychiatric illness, mental health treatment, alcoholism, or drug use: (Parents, siblings, extended family members)

_____

_____

_____

Has anyone: □ Been psychiatrically hospitalized □ Received psychiatric treatment □ Neither

If yes, who? _____

Has anyone attempted to commit suicide? □ Yes □ No If yes, who? _____

Has anyone committed suicide? □ Yes □ No If yes, who? _____

7. FAMILY MEDICAL HISTORY (Diabetes, Stroke, Heart Disease, Cancer, etc.):

Please list any medical conditions of the following family members:

Father: _____

Alive? □ Yes □ No If no, cause of death and/or illness: _____

Mother: _____

Alive? □ Yes □ No If no, cause of death and/or illness: _____

8. SUBSTANCE USE/ABUSE HISTORY:

Have you ever had any alcohol? □ Yes □ No

Age when you first had a drink: _____ How often do you drink? _____

Date you last drank: _____ Drink of choice? □ Beer □ Wine □ Liquor

Have you ever used illicit / street drugs? □ Yes □ No

If yes, please list: _____

Age you first used drugs: _____ How often do you use drugs? _____

Date you last used drugs: _____ What did you use? _____

Have you ever smoked tobacco? □ Yes □ No

Age you first smoked tobacco: _____ Are you currently a smoker? □ Yes □ No

How often do you smoke? _____ How many packs per day? _____

Number of attempts at quitting: _____ Date you quit: _____

Have you previously been tried on: (*Circle all that apply*)

Naltrexone	**Campral**	**Antabuse**	**Vivitrol**	**Methadone**
Suboxone	**Zubsolv**	**Subutex**	**Sublocade**	**Buprenorphine**

Have you sought substance/alcohol abuse treatment in the past? ❑ Yes ❑ No

Are you currently involved in substance/alcohol abuse treatment? ❑ Yes ❑ No

Name: _____ DOB: _____

Do you currently have or had in the past any legal issues related to substance or alcohol?

❑ Yes ❑ No

Please list all treatment programs you have been involved in or are currently involved in:

(Please include dates, length of treatment, any AA/NA/SOS meetings, frequency per week, sponsor)

_____

_____

_____

_____

_____

9. SOCIAL HISTORY:

Please list whom you live with: _____

_____

Do you have a good support system? (Including family and/or friends) □ Yes □ No

If yes, please list who: _____

_____

Do you have any children? □ Yes □ No If yes, how many? _____

_____

10. LEGAL:

Do you have any pending legal issues? □ Yes □ No

If yes, what are they? _____

_____

Do you have any pending court appearances? □ Yes □ No

If yes, please list when and what for: _____

_____

11. WORK:

Are you currently employed? □ Yes □ No

Current title/position: _____ Employer: _____

Are you currently on disability? □ Yes □ No

If yes, date you became disabled: _____ Who put you on disability? _____

12. INTERESTS/LEISURE:

Please list any hobbies/activities you enjoy: _____

_____

13. DEVELOPMENT:

Birth history: □ Full term □ Preterm

Delivery: □ C-section □ Vaginal

Complications: □ Yes □ No

If yes, please list: _____

_____

How did you do in elementary school? _____

Did you have any delays in walking, talking, or reading? □ Yes □ No

If yes, what were they? _____

_____

Name: _____ DOB: _____

Did you require any special classes or accommodations? □ Yes □ No
If yes, what classes? _____
Highest grade or level of education completed: _____
Have you ever been abused: (*Mark all that apply*)
□ Emotionally □ Physically □ Sexually

14. Is there anything else you would like to add about yourself that has not been covered?

_____
_____
_____
_____
_____
_____
_____

Thank you.

Name: _____ DOB: _____

(Intentionally Left Blank)

Name: _____ DOB: _____

Mood Disorder Questionnaire (MDQ)

Instructions: Please answer each question as best as you can.

1. Has there ever been a period of time when you were not your usual self and…	**Yes**	**No**
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got in trouble?	☐	☐
…you were so irritable that you shouted at people or started fights or arguments?	☐	☐
…you felt much more self-confident than usual?	☐	☐
…you got much less sleep than usual and found you didn't really miss it?	☐	☐
…you were much more talkative or spoke much faster than usual?	☐	☐
...your thoughts raced through your head or you couldn't slow your mind down?	☐	☐
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
…you had much more energy than usual?	☐	☐
…you were much more active or did many more things than usual?	☐	☐
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
…you were much more interested in sex than usual?	☐	☐
…you did things that were unusual for you or that other people might have thought were excessive, risky, or foolish?	☐	☐
…spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?
Please circle one response only

No problem Minor problem Moderate problem Serious problem

4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

(Intentionally Left Blank)

Please complete to the best of your ability of which of the following medications you have previously tried. If possible, please add at what dose you tried, dates taken, and any side effects or adverse effects. Thank you.

Medications Trials						
CLASSIFACTION	**Check If Tried**	**Brand Name**	**Generic Name**	**Doses Tried**	**Dates Used**	**Side Effects?**
SSRI		Celexa	citalopram			
		Lexapro	escitalopram			
		Luvox	fluvoxamine			
		Paxil	paroxetine			
		Paxil CR	paroxetine			
		Prozac	fluoxetine			
		Zoloft	sertraline			
SNRI		Cymbalta	duloxetine			
		Effexor (XR)	venlafaxine (ER)			
		Fetzima	levmilnacipran			
		Pristiq	desvenlafexine			
		Savella	milnacipran			
Other Antidepressants		Desyrel	trazodone			
		Remeron	mirtazapine			
		Serzone	nefazodone			
		Trintellix	vortioxetine			
		Viibryd	vilazodone			
		Wellbutrin (SR)(XL)	buproprion			
Tricyclic Antidepressants		Anafranil	clomipramine			
		Asendin	amoxapine			
		Elavil	amitriptyline			
		Norpramin	desipramine			
		Pamelor	nortriptyline			
		Sinequan	doxepin			
		Surmontil	trimipramine			
		Tofranil	imipramine			
MAOI		EMSAM	selegiline			
		Nardil	phenelzine			
		Parnate	tranylcypromine			

Medications Trials

CLASSIFACTION	Check If Tried	Brand Name	Generic Name	Doses Tried	Dates Used	Side Effects?
Mood Stabilizers/ Anticonvulsants		Depakote	valproic acid			
		Depakote (ER)	divalproex sodium			
		Horizant	gabapentin enacarbil			
		Keppra	levetiracetam			
		Lamictal (XR)	lamotrigine			
		Lithium	lithobid			
		Lyrica	pregabalin			
		Neurontin	gabapentin			
		Tegretol	carbamazepine			
		Topamax	topiramate			
		Trileptal	oxcarbazapine			
		Zonegran	zonisamide			
Antipsychotics		Abilify	aripiprazole			
		Abilify Maintena	aripiprazole injectable			
		Aristada	aripiprazole lauroxil			
		Clozaril	clozapine			
		Fanapt	lloperidone			
		Fluphenazine	prolixin			
		Geodon	ziprasidone			
		Haldol	haloperidone			
		Haldol Decanoate	haloperidol			
		Invega	paliperidone			
		Invega Sustenna	paliperidone palmitate			
		Invega Trinza	paliperidone palmitate			
		Latuda	lurasidone			
		Loxapine	loxitane			
		Mellaril	thioridazine			
		Navane	thiothixene			
		Orap	pimozide			
		Phenergan	promethazine			
		Rexulti	brexpiprazole			
		Risperdal	risperidone			
		Risperdal Consta	risperidone (ER)			
		Saphris	asenapine			
		Seroquel (XR)	quetiapine			
		Symbyax	fluoxetine /olanzapine			
		Thorazine	chlorpromazine			
		Trifluoperazine	stelazine			

Medications Trials

CLASSIFACTION	Check If Tried	Brand Name	Generic Name	Doses Tried	Dates Used	Side Effects?
Antipsychotics continued		Trilafon	perphenazine			
		Vraylar	cariprazine			
		Zyprexa	olanzapine			
		Zyprexa Relprevv	olanzapine (ER)			
Benzodiazepines / Anxiolytics		Ativan	lorazepam			
		Buspar	buspirone			
		Inderal	propranolol			
		Klonopin	clonazepam			
		Librium	chlordiazepoxide			
		Oxazepam	oxazepam			
		Restoril	temazepam			
		Tranxene	clorazepate			
		Valium	diazepam			
		Vistaril	hydroxyzine			
		Xanax	alprazolam			
Stimulants		Adderall (XR)	amphetamine			
		Concerta	methylphenidate			
		Desoxyn	methamphetamine			
		Dexedrine	dextroamphetamine			
		Evekeo	amphetamine			
		Focalin (XR)	dexmethylphenidate			
		Ritalin	methylphenidate			
		Vyvanse	lisdexamfetamine			
Misc Stimulants		Catapres	clonidine			
		Intuniv	guanfacine			
		Nuvigil	armodafinil			
		Provigil	modafinil			
		Strattera	atomoxetine			
Sleep Aids		Ambien (CR)	zolpidem			
		Belsomra	sovorexant			
		Lunesta	eszopiclone			
		Melatonin	melatonin			
		Rozerem	ramelteon			
		Sonata	zaleplon			
		Unisom	doxylamine			

Medications Trials						
CLASSIFACTION	**Check If Tried**	**Brand Name**	**Generic Name**	**Doses Tried**	**Dates Used**	**Side Effects?**
Supplements		Deplin	levomefolic acid			
		Folic Acid	folate			
		Omega 3 Fatty Acid				
		Vitamin D				
		Vitamin B12				

Non-Pharmacological Therapies		
Therapy	**Date Range**	**Location**
Transcranial Magnetic Stimulation (TMS)		
Electroconvulsive Therapy (ECT)		
Ketamine Therapy		

Psychotherapy		
Therapist Name	**Date Range**	**Location**

Thank you!

I acknowledge that the above information is correct and co-relates with my psychiatric history to the best of my knowledge.

Print Name: _____ **DOB:** _____

_____ **Date**: _____

Signature