www.ADHD-Medical.com
(251) 243-7058

Appointment Request Form

A $100.00 DEPOSIT IS REQUIRED WHEN SCHEDULING AN APPOINTMENT *

Is patient currently under a physician's care for treatment of ADHD? Yes_____ No_____
If yes, please provide the physician's name. _________________
Is patient currently taking medication for treatment of ADHD? Yes_____ No_____
Were you referred to ADHD Medical Clinic by a medical professional? Yes_____ No_____
If yes, please provide name of professional. _________________
If no, how did you hear about us? _________________

Patient Information

First_______________________________ Middle______________________ Last Name_________________________

Preferred Name __________________________ Date of Birth _________________ Male _______ Female ________

Patient Mailing Address _______________________________City ___________________St ______Zip___________

Patient Cell Phone _________________________________Patient Home Phone _______________________________

Work Phone _______________________________________ Primary Phone Number____________________________

Patient Email Address ____

Parent/Spouse Information (if applicable)

Name of Parent/Spouse/Legal Guardian _______________________________Cell #____________________________

Relationship to patient _______________________Is 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 the responsible party along with insurance information in the insurance section below.

Patient Consent (if over the age of 18)

I give ADHD Medical Clinic of Mobile my consent to contact the individual(s) above should additional information be required to schedule 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 # ___________________

Initial __________ *A $100 deposit is required when scheduling a new patient appointment to hold your appointment spot. This deposit will be placed on your account as a credit to be used toward copays, case management fees, or any non-covered services. The deposit remains fully refundable until 24 hours prior to the appointment. If an appointment is missed or rescheduled within 24 hours of the appointment time, the deposit becomes non-refundable, and another deposit must be made to schedule a new appointment.

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Please Email Completed Form to office@adhd-medical.com