Initial Contact Form

Dr Moazen Psychiatry

First and Last name: *

Date of Birth (mm/dd/yyyy): *

Phone number: *

Email: *

How did you learn about my practice? *

Through a friend
Through a provider
Online search

What are you seeking help for? *

Are you currently in psychotherapy and/or taking a psychiatric medication? *

Both
Only psychotherapy
Only medication
None

Have you ever had any suicidal thoughts (either past or present)? * Yes No

Have you ever been hospitalized psychiatrically? * Yes No

Do you use any of the following substances more frequently than once a day? *

- [ ] Alcohol
- [ ] Cannabis
- [ ] Nicotine
- [ ] Opioids
- [ ] Stimulants (non-prescription)
- [ ] None

Do you have health insurance in the USA? * Yes No

If yes, what insurance company/plan?

UMR Top Tier
Medicaid
Other (specify)
Medicare

I am aware that Dr. Moazen Psychiatry is out-of-network with all other insurance plans (besides Mount Sinai UMR Top Tier). This means that I am willing to pay for services at time of service and submit super bills to my insurance to be reimbursed directly. *

Yes No

I am open to tele-health/virtual visits? * Yes No

I am able to be physically located in New York State or New Jersey at the time of my visits? * Yes No