Patient Information

Callers Name: _____Relationship to Pt.:_____

Patient's First Name:_____Middle Initial_____ Last Name:_____

Age: _____ Sex: _____ Date of Birth: _____Marital Status: _____

Address: _____City_____ Zip _____

Home Ph: _____Cell Ph: _____ Work Ph: _____

Employer/Student (school/grade) _____

Primary Insurance Co._____ Phone: _____

ID#: _____ Group#: _____

Policyholder Name: _____ Date of Birth: _____

Employer: _____Relationship to Pt._____

Secondary Insurance Co. _____Phone: _____

ID#: _____ Group#: _____

Policyholder Name: _____ Date of Birth: _____

Employer:_____ Relationship to Pt:_____

Previous Treatment:(Outpatient/Inpatient/PHP)_____

PCP Name: _____Phone:_____

Emergency Contact: _____ Phone: _____Relationship: _____

Referred by: _____

Reason for Seeking Treatment:_____

❑ Currently using Alcohol or other Substance or History of S/A?	❑ Currently on Sick Leave/FMLA or Seeking Sick leave?
❑ Related to Auto Accident? Date of accident _____	❑ Other Releases needed? (Probation/School)
❑ Special communication needs? Yes or No	❑ Advised to arrive 30 min. early, address given

Therapist Assigned: _____ Intake Appointment Date: _____ Time: _____

Information Taken By:_____Date:_____