

Patient Information

Date:	Referred by:		
Last Name:	First Name:	Middle:	
Address:	City:	State:	Zip Code:
Home Phone: ()	Work Phone: ()	Pager/Cell Phone: ()	
E-Mail Address:	Date of Birth:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Separated/Divorced	
Emergency Contact Name:	Relationship:	Phone: ()	
Address:	City:	State:	Zip Code:

Insurance Information

Subscriber Name:	Subscriber Birthdate:		
Insurance Company:	Subscriber Employer:		
Subscriber Insurance ID# (including Alpha characters):	Group #:	Copay Amount: \$	
Patient Relationship to Subscriber:	Patient Insurance ID# (including Alpha characters):		
Has patient used his/her Mental Health Benefits this year? Yes No			

Parent/Guardian/Foster Parent Information

(if other than patient)

Name:	Address:	City:	State/Zip Code:
Home Phone: ()	Work Phone: ()	Relationship to Patient:	