INTAKE FORM – REFERRAL

DATE: _____
NAME (first name)_____(last name)_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____
PHONE:_____ALT.PHONE_____Email:_____

DATE OF BIRTH:_____AGE:_____SEX:_____RACE:_____
Marital Status Single ____Widow _____Married _____ Separated ___Never Married
____Religion:

GUARDIAN / CONTACT PERSON INFORMATION

NAME: _____RELATIONSHIP: _____PHONE: _____Email: _____
ADDRESS: _____ CITY: _____ STATE:
____ZIP:_____
IS CLIENT A TEMPORARY/PERMANENT WARD OF THE COURT? YES_____NO_____
DSS WORKER NAME: _____ Phone: _____

INSURANCE INFORMATION ____ PSP _____HMO_____ CLINIC PLAN _____
MEDICARE
PRIMARY INSURANCE NAME _____
ID#:_____/_____/_____GROUP# __PLANE CODE _____
SECONDARY INSURANCE NAME
_____
ID#:_____/_____/_____GROUP# __PLANE CODE _____
POLICY HOLDER: _____ DOB: _____
RELATIONSHIP_____
EMPLOYED BY:_____ YRS_____PHONE# _____
VERIFICATION INFORMATION: _____

ADDITIONAL INFORMATION

DIAGNOSIS: _____ CODE: _____
REFERRED BY: _____ PHONE: _____

PERSON CALLING: _____ RELATIONSHIP: _____PHONE _____
IS CLIENT CURRENTLY ON PROBATION OR PAROLE? YES _____NO_____
PROBATION / PAROLE OFFICER: _____ PHONE _____
LOCATION: _____
PRESNTING PROBLEMS: _____

DO YOU LIVE IN A PRIVATE HOME? YES ____ NON ____ IF no complete below
TYPE OF HOUSING: _____
NAME OF RESIDENCE: _____
ADDRESS: _____
CITY STATE ZIP: _____
PHONE: _____ ALT PHONE: _____
PERSON TO CONTACT FOR ADDITIONAL INFORMATION: _____

_____ _____
CLIENT SIGNATURE DATE

INTAKE STAFF: _____ DATE: _____