PATIENT INFORMATION SHEET

Date _____ **Time** _____

Please Print All Information

Patient Information

Last Name _____ First Name _____ Middle Name _____

Age _____ Date of Birth _____ SS# _____ Race _____

Street Address _____ Home Phone (____) _____

City/State/Zip _____ County _____

School _____ Phone (___) _____

Grade _____ Teacher _____ Religion _____

Legal Guardian Information

Name (First & Last) _____ Relationship to Patient _____

Date of Birth _____ SS# _____ Email _____

Street Address _____ Home Phone (____) _____

City/State/Zip _____ Cell Phone (____) _____

Employer Name _____ Other Phone (____) _____

Employer Address _____ Work Phone (____) _____

City/State/Zip _____ Occupation _____

Guarantor (Person responsible for bill---if same as above, please put "Same")

Name (First & Last) _____ Relationship to Patient _____

Date of Birth _____ SS# _____ Email _____

Street Address _____ Home Phone (____) _____

City/State/Zip _____ Cell Phone (____) _____

Employer Name _____ Other Phone (____) _____

Employer Address _____ Work Phone (____) _____

City/State/Zip _____ Occupation _____

Emergency Contact 1 (Person Other Than Legal Guardian or Guarantor-If Applicable)

Name (First & Last) _____ Relationship to Patient _____

Street Address _____ Home Phone (____) _____

City/State/Zip _____ Other Phone (____) _____

Emergency Contact 2 (Person Other Than Legal Guardian or Guarantor-If Applicable)

Name (First & Last) _____ Relationship to Patient _____

Street Address _____ Home Phone (____) _____

City/State/Zip _____ Other Phone (____) _____

Insurance Information (Please Bring All Insurance Cards To The Assessment)

Primary Insurance Name_____ Phone (____) _____

Policy Holder Name _____ Date of Birth _____ SS# _____

Policy Holder's Relationship to Patient _____ ID/Policy # _____

Group#_____ Group Name _____

Secondary Insurance Name_____ Phone (____) _____

Policy Holder Name _____ Date of Birth _____ SS# _____

Policy Holder's Relationship to Patient _____ ID/Policy # _____

Group#_____ Group Name _____

Tertiary/3rd Insurance Name_____ Phone (____) _____

Policy Holder Name _____ Date of Birth _____ SS# _____

Policy Holder's Relationship to Patient _____ ID/Policy # _____

Group#_____ Group Name _____

DHS/OJA Information

Caseworker Name _____ Work Phone (_____) _____ **DHS or OJA**

Cell (____) _____ Other Phone/Pager (____) _____ Pin # _____

County _____ Address _____

City/State/Zip _____ **Fax #** (____) _____

Supervisor Name _____ Work Phone (_____) _____

Cell (____) _____ Other Phone/Pager (____) _____ Pin # _____

County Director Name _____ Work Phone (_____) _____

Cell/Other (____) _____ Fax # (____) _____

Current Medication Information

Name of Medication	Start Date	Dosage	Times Given	Prescribing Physician

Previous Medication Information

Name of Medication	Start Date	Dosage	Times Given	Prescribing Physician

Allergies Information

Food Allergies _____

_____

Medication Allergies _____

_____

Medical Information

Does patient have any significant medical conditions that require on-going monitoring? Yes or No

If yes, please explain _____

_____

_____

Drug or Alcohol Use

Has patient used any illicit drugs or alcohol in the past 24 hours? Yes or No

If yes, please explain _____

_____

_____

Previous/Current Provider Information

	First and Last Name:	Phone Number:	Agency/Clinic:
Primary Physician:		( )	
Psychiatrist:		( )	
Therapist/Counselor:		( )	