PATIENT INFORMATION SHEET **Date** ____________________ **Time** ____________

Please Print All Information

Patient Information

Last Name __________________________ First Name __________________________ Middle Name _______________

Sex M or F Age ____ Date of Birth _____________ SS# ____________________________ Race ____________

Street Address ____ Home Phone (____) _________________

City/State/Zip ____ County ___________________

School ____ Phone (___) ______________________

Grade ________ Teacher ________________________________ Religion ___________________________________

Is the patient in the custody of *(please check if applicable)*? ☐ DHS ☐ OJA ☐ Tribe

Parent &/or Legal Guardian Information

Name (First & Last) ____ Relationship to Patient ________________

Date of Birth ________________ SS# ________________________________ Legal Guardian? Yes or No

Street Address ____ Home Phone (____) _________________

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

Employer Name ____ Work Phone (____) _________________

Employer Address ____ Email ______________________________

City/State/Zip ____ Occupation __________________________

Guarantor &/or Other Parent/Legal Guardian (Person responsible for bill---if same as above, please enter "Same")

Name (First & Last) ____ Relationship to Patient ________________

Date of Birth ________________ SS# ________________________________ Legal Guardian? Yes or No

Street Address ____ Home Phone (____) _________________

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

Employer Name ____ Work Phone (____) _________________

Employer Address ____ Email ______________________________

City/State/Zip ____ Occupation __________________________

Emergency Contact or Other Legal Guardian (Person Other Than Persons Listed Above-If Applicable)

Name (First & Last) ____ Relationship to Patient ________________

Legal Guardian? Yes or No

Street Address ____ Home Phone (____) _________________

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

Emergency Contact or Other Legal Guardian (Person Other Than Persons Listed Above-If Applicable)

Name (First & Last) ____ Relationship to Patient ________________

Legal Guardian? Yes or No

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 ____________________________________

Patient Name ________________________________ **Date of Birth** _______________

DHS/OJA/Tribal Caseworker Information

Caseworker Name ______________________________ Work Phone (_____) _________________ **DHS or OJA or Tribal** *Please Circle One*

Tribe Affiliation *(if applicable)* ____

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:	________________________	( ) ______________	______________

Legal Guardian Verification

I hereby verify that I am the legal guardian and have permission to approve admission of this child.

There is no involvement with DHS, OJA, or Tribal affiliation unless identified above.

____ ________________

Legal Guardian's Signature Date