

Last: _____	First: _____
S.S. # _____	Date of Birth: _____
M.R. # _____	Admission Date: _____

FACE SHEET

Client: _____ Social Security Number: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Marital Status: _____ Primary Language: _____ Ethnicity: _____

Emergency Contact: _____ Relation: _____ Contact Phone: _____

Living Situation: _____

Occupational Status: _____ Highest Grade Completed: _____

Referral Source: _____ Contact: _____ Phone: _____

PROFESSIONAL CONTACTS

PCP/Physician: _____ Last Seen: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Mental Health Site: _____ Last Seen: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Case Manager: _____ Psychiatrist: _____

INSURANCE INFORMATION

Insured Name (Last, First, Middle Initial): _____ Insured's Date of Birth: _____

Insured's Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Primary Payer: _____ Policy Number: _____ Group: _____ Client Relation to Insured: _____

Secondary Payer: _____ Policy Number: _____ Group: _____ Client Relation to Insured: _____

Additional Information: _____

LEGAL INVOLVEMENT

Client denies any legal involvement Client has Payee: _____ Phone: _____

Client has Legal Guardian - Name of Legal Guardian: _____ Phone: _____

Client currently being Court Ordered to Treatment for: DTO DTS PAD GD Date Expires: _____

On Probation On Parole Officer Name: _____ Phone: _____ Fax: _____

Address: _____ City: _____ State: _____ Zip: _____

Additional Information: _____