CHILD • ADOLESCENT • ADULT

MENTAL HEALTH SERVICES

Name: _____, _____ ___ DOB: _____
Last First Mi.

Address: _____ _____ _____ _____ _____
Street # City State Zip code

Phone: _____ Email: _____

Insurance Company Name: _____ Member ID: _____

Have you been here before? ☐ Y ☐ N (if yes who did you see & how long ago)_____

Reason for visit: _____

Have you recently been discharged from the hospital? ☐ **Yes** ☐ **No**

If yes, Hospital: _____ Date of Discharge:

RESET **SUBMIT FORM**

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