Information Needed for Admission and Enrollment

Patient's Name: _____ **Date of Birth:** _____ **SSN#:** ___ - ___ - ____

Your Contact Information: Include all Contact Numbers

Primary Parent/Guardian Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: H- _____ W- _____ C- _____
Spouse Name: _____ W- _____ C- _____
e-mail- _____
Other Parent Name if Applicable: _____ ☐ No Rights
Address: _____ City: _____ State: _____ Zip: _____
Phone: H- _____ W- _____ C- _____
Spouse Name: _____ W- _____ C- _____
e-mail**:** _____

Emergency Contact Information: (Non Parent/Guardian) Other than Listed Above
Name: _____ Relationship: _____ Phone Number: _____
Address: _____ City: _____ State: _____ Zip: _____

Insurance Information:
Subscriber Name: _____ Subscriber Date of Birth: _____
Insurance Co.: _____ ID/Subscriber # _____
Employer: _____

Psychiatrist: First & Last Name: _____
Address: _____ City: _____ State: _____ Zip _____
Phone number: _____ Fax: _____
e-mail: _____

Therapist: First & Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Fax: _____
e-mail: _____

Primary MD: First & Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Fax: _____
e-mail: _____

Any other Release needed for a provider / Probation, Education Consultant etc…
First & Last Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone number: _____ Fax: _____
e-mail: _____

Names of Hospitals / Residential Programs Patient has Attended Most Recently:
Name: _____ City: _____ State: _____ Zip: _____
Name: _____ City: _____ State: _____ Zip: _____
Name: _____ City: _____ State: _____ Zip: _____

School: _____ **City/State:** _____ **Grade:** _____

State of Birth: _____ **Religion:** _____