SAINT FRANCIS
Behavioral Health Group
Building brighter tomorrows.

Patient Information Form

Date_____

PATIENT INFORMATION

Patient's Name_____ Date of Birth_____ Male ☐ Female ☐

Address_____ Single ☐ Married ☐ Divorced ☐

City, State & Zip _____ RACE_____ETHNICITY_____PRIMARY LANGUAGE _____

Home Phone (_____) _____ Cell Phone (_____) _____ Social Security# _____

(My Chart) YES ☐ NO ☐ Email Address_____

Emergency Contact_____ Employer_____

Phone (H) (_____) _____ (W) (_____) _____(C) (_____) _____

Primary Care Physician_____ Physician's Phone (_____) _____

Pharmacy Name _____ Address _____

Phone # (____) _____

PARENT/RESPONSIBLE PARTY INFORMATION

Parent/Responsible Party/Legal Guardian _____ Relationship_____

Address_____ City, State _____

Phone _____

Date of Birth_____ Social Security # _____

INSURANCE INFORMATION

Primary Insurance Company_____ Policy #_____

Subscriber's Name (***if different than patient***) _____ Relationship _____

Address_____ Phone (_____) _____

Date of Birth_____ SS#_____

Secondary (***if applicable***) Insurance Company_____ Policy #_____

Subscriber's Name (***if different than patient)*** _____ Relationship_____

Address_____ Phone (_____) _____

Date of Birth_____ SS#_____