Behavioral Healthcare of Fredericksburg
312 Progress Street, Suite 200, Fredericksburg, VA 22401

ADULT INTAKE

Office use only

Date:______________________ Referred by:________________________________ Dx:

Name:____ SS #______________________

Address:____ Home/Cell Phone: ( )______________________

City, State & Zip ____ Work Phone: ( )______________________

Date of Birth________________________ Gender *Male* *Female* Marital Status *Married* *Single* *Other*

E-Mail:___________________________________

Name, Age and Relationship of Others Living with patient: ____

____

I am here because: ____

____

Have you seen any other Mental Health Professional within the past year? *Yes* *No*

Name of Practitioner:____

Patient Insurance Information

Insurance Company ____________________________________

ID # ____________________________________

Primary Name ____________________________________

Insured's Address (if same as above, write same) ____________________________________

____

Insured's Birth date ________________________ Male Female

Patient's Relationship *Self* *Spouse* *Child* *Other*

Employer ____________________________________

If required by my insurer, I have already contacted my insurer and received authorization for services with this office (Circle one) *Yes* *NO*