PERSONAL INFORMATION:
Please print and complete ALL sections:

Patient Name: _____ Circle: Male or Female

Date of Birth: _____Place of Birth:_____

Social Security Number:_____

Parents/Guardian's Name:_____

Permanent Street Address:_____

City/State/Zip: _____

Email Address:_____

Permanent Phone: _____ Cell Phone:_____

Temporary Street Address (if applicable):_____

City/State/Zip:_____

Temporary Phone:_____

MEDICAL INFORMATION:
This section must be accompanied by a letter from a hospital professional (i.e: social worker):
Name of Hospital: _____Phone: _____

Mailing Address:_____

City/State/Zip:_____

Social Worker: _____ Phone:_____

Pager: _____ Email Address: _____

Treating Physician: _____ Phone: _____

Diagnosis:_____ Date of Diagnosis: _____

Other Treatment Facilities Attended:
_____

Mailing Address: _____

City/State/Zip: _____ Phone: _____

INSURANCE INFORMATION:
Patient covered by Insurance? Yes or No Patient covered by Medicaid? Yes or No

Insurance Plan Name: _____

Policy Number: _____% of Coverage: _____

Address of Insurance Company:
_____

City/State/Zip: _____ Phone: _____

Does Insurance provide assistance with meals, transportation or lodging expenses? Yes or No

Secondary Insurance? Yes or No If so, Name of Plan:_____

Have you filed for Medicaid? Yes or No If so, have you been approved for Medicaid? Yes or No