

Barth & Associates
Barth Clinic * Barth Family Programs * Barth Consulting, INC
PATIENT INFORMATION FORM

Date _____

NAME: Last _____ First _____ Middle Initial _____ SS# _____ - _____ - _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

MAILING ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PHONE () _____ - _____ WORK PHONE () _____ - _____

CELL PHONE/PAGER() _____ - _____

DATE OF BIRTH _____ AGE _____ SEX _____

Reason for Referral (Circle one of the following): Court Order Attorney Employment Family EAP Other
Please explain: _____

RACE (circle) Black White Hispanic Mexican Native American Asian Other:

Driver's License No.: _____ State _____

Employment Status: Full Time _____ Steady, but less than 30 hours per week _____
Temporary _____ In School _____ Unemployed/not in school _____

Employer: _____

Physicians name: _____ Hospital: _____

List any medications you are allergic to: _____

Medical Insurance Benefits: **Yes / No** Group or Policy Number: _____

Name of Medical Insurance Company _____

Marital Status: Single / Married / Divorced or Separated Spouse's Name: _____

Spouse's Employer: _____

Medical Insurance Benefits: **Yes / No** Group or Policy No. _____

Name of Medical Insurance Company _____

EMERGENCY CONTACT PERSON: Name _____ Phone # _____

Relationship _____ Address _____

Have you ever been to any Barth Family Programs before: **Yes / No** When: _____

DO NOT WRITE BELOW THIS LINE

Intake Counselor _____

Date of Appt: _____

TIME: _____

Pre-Paid: _____