

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 (select one): Attorney Court Order EAP Employment Family Other

Please explain: _____

RACE (select one) Black White Hispanic Mexican Native American Asian Other

Driver's License No.: _____ State _____

Employment Status:
Full Time Steady(but less that 30 hrs 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 _____

Living Status: Single Married Divorced Separated Partner / Mate / Significant Other

Name _____

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: _____