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): Attorney Court Order EAP Employment Family Other

Please explain: _____

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

Driver's License No.: _____State_____

Employment Status: Full Time___ Steady, but less that 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_____

Living Status: Single / Married / Divorced or 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: _____