Behavioral Health Choices

Intake Form

Demographics:

Name:_____DOB:_____
Parent's names (if a minor):_____
_____
Address:_____
_____
_____
Tel: home:_____
cell:_____
work:_____
Email:_____

Primary Insurance:_____
Primary Insured's name:_____Primary Insured's DOB:_____
Patient's relationship to Primary Insured:_____
Insurance ID:_____