SERENE MENTAL HEALTH

*** *** *** *** *** **PLEASE PRINT CLEARLY** *** *** *** *** ***

Today's Date: ____ /____ /_____

Patient's Name: _____

Preferred Name (if different from above): _____

Date of Birth:____-_____-_____

Age:____ yrs old

Gender : M F

Social security #: _____-_____-_____

Address: _____

City:_____ **State:** _____ **Zip:**_____

Phone #: Home (_____)_____-_____

Mobile (_____)_____-_____

Appointment reminder (check ONE): ___ Call Home ___ Call Cell ___ Text Cell ___ E-mail

E-Mail : _____

GUARDIAN (if appropriate):

Name: _____ Relationship to patient: _____

Date of Birth: _____-_____- _____ Social Security #: _____-_____-_____

Phone #: Home (____)_____-_____

Mobile (____)_____-_____

Work (____)____-_____

Address: _____City:_____ State: ____ Zip: _____

Other Members of Household:

Name	Age	Relationship to *Patient*
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT OCCUPATION: _____

Employment Status(circle one): Full-time Part-time Unemployed Homemaker Student Other

Veteran: __ yes __ no

INSURANCE

Policy Holder: _____ Subscribers DOB: ___/____/____ SS#: ____-___-___

Address: _____

Insurance Provider, Medicaid, or Self Pay: 1) _____ 2) _____

ID #: 1) _____ 2) _____

Group #: 1) _____ 2) _____

Marital Status(circle one): Single Married Separated Divorced Widowed

Religious Preference (optional): _____

Education (highest grade earned): ____Grade ____High School ____College-Degree: _____

COUNSELING

Are you currently receiving other counseling: ___yes ___ no

Current counselor:

Name:_____ Facility:_____

PREVIOUS Counseling Experiences (Mental Health Medication or Therapy):

Name	Location	Approximate Dates
_____	_____	_____
_____	_____	_____
_____	_____	_____

REFERED BY: _____

IN CASE OF EMERGENCY notify:

Name: _____ Relationship: _____

Phone#: Mobile (____)_____-_____

Home (____)_____-_____

Work (____)_____-_____

Primary Care Physician: _____Facility:_____

MEDICATION:_____

_____

_____

Existing Medical Conditions:_____

_____

ALLERGIES: _____

Special Treatment (if any): _____

PHARMACY:_____ City:_____ , NE

All of the above information is current to the best of my knowledge:

_____ _____

Patient or Guardian Signature Date