BETTER MOOD CLINIC OF SOUTH GA, LLC
2935 N ASHLEY ST. BLDG F, VALDOSTA, GA 31602

DATE: _____
STAFF INITIALS: _____
IN-HOUSE REFERRAL: _____
EXTERNAL REFERAL: _____

NEW CHILD REFERRAL (except psychological testing)

PATIENT INFORMATION

Legal Name (Last, First, MI): _____ Date of Birth: _____ Age: _____
Name of caller / Relationship to patient: _____ Gender: Male / Female / Other
U.S. Citizen: Yes / No. If no, what country are you a citizen of_____
Personal Identification Number (DoD, Social Security, or Resident Alien Card): _____
Grade in school: _____ School: _____ Lives With: _____
Legal Address: _____
Primary Phone Number: _____ (Home / Cell) OK to call you here: YES / NO
E-mail Address: _____ OK to e-mail you: YES / NO
Emergency Contact (Name/Relationship): _____ Ph number: _____

ARE YOU A LEGAL GUARDIAN? PLEASE ATTACH DOCUMENTATION TO SUPPORT THIS RELATIONSHIP

GUARDIAN (as applicable): Name _____ / Relationship to Patient: _____

Parent/Guardian's SSN: _____ Parent/Guardian DOB: _____

INSURANCE INFORMATION

Primary Insurance Company_____ Insurance ID Number _____
Deductible: _____ Co-Pay: _____ Other: _____

ADDITIONAL INFORMATION

Referred by: _____Primary Care Provider: _____ Pharmacy: _____
Have you been seen by a mental health provider before: Yes / No; if yes, with whom and why:
_____
_____

REASON FOR APPOINTMENT: Depression / Anxiety / Behavioral / Legal / Other: _____
_____
_____
_____
_____

How would you rate your child's symptoms? Mild / Moderate / Severe: Length of concern: _____
Do these concerns affect school performance? Yes / No; if yes, how so? _____
_____

Is your child at risk to self or another now? Yes / No; if yes refer to SGMC/Greenleaf (247-4357)
To your knowledge, has child intentionally harmed self? Yes / No; if yes what happened/when:
_____

Does your child have special needs such as: hearing impaired, illiterate or need an interpreter? _____

BMC provider? _____ Appt Date & Time: _____

The above information is TRUE to the best of my knowledge. Parent / Guardian Signature: _____