

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

DATE: \_\_\_\_\_  
STAFF INITIALS: \_\_\_\_\_  
IN-HOUSE REFERRAL: \_\_\_\_\_  
EXTERNAL REFERRAL: \_\_\_\_\_

**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:** \_\_\_\_\_