

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 PATIENT 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
Relationship Status: Single / Living with Significant Other / Married / Separated / Divorced / Widowed
U.S. Citizen: Yes / No. If no, what country are you a citizen of _____
Personal Identification Number (DoD, Social Security, or Resident Alien Card): _____
Military Status: No military history / Active Duty / Reserve / Guard / Separated / Retired
Grade in school _____ / Highest Level of Education: GED / HS / College / Grad School / Prof Degree
School or Employer _____ Job Title _____
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: _____

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 symptoms? Mild / Moderate / Severe: Length of concern: _____
Do these concerns affect school / work performance? Yes / No; if yes, how so? _____

Are you at risk to yourself or another now? Yes / No; if yes refer to SGMC/Greenleaf (247-4357)
Have you ever intentionally harmed yourself? Yes / No; if yes what happened/when: _____

Do you have special needs such as: hearing impaired, illiterate or in need of an interpreter? _____

BMC provider? _____ Appt Date & Time: _____

All information above is **TRUE:** **Print name:** _____ **Signature:** _____