BETTER MOOD CLINIC OF SOUTH GA, LLC **DATE:** _____
2935 N ASHLEY ST. BLDG F, VALDOSTA, GA 31602 **INITIAL:** _____
IN-HOUSE REFERRALL: _____

PATIENT INFORMATION

Legal Name (Last, First, MI): _____ Date of Birth: _____ Age: _____
Name of caller /Relationship to patient: _____ Gender: Male / Female
Relationship Status: Single / Living w / 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: _____

GUARDIAN INFORMATION (as applicable):

Parent (s) or Legal Guardian / Relationship to Patient: _____
IF YOU ARE THE LEGAL GUARDIAN WE NEED DOCUMENTATION SUPPORTING THIS RELATIONSHIP

INSURANCE INFORMATION

Primary Insurance Company_____ Secondary Insurance Company: _____
Name of Policy Holder _____ Insurance ID Number _____
Effective Date: _____ Deductible: _____ Network – In / Out Co-Pay: _____

ADDITIONAL INFORMATION

Primary Care Physician: _____ Pharmacy Name /Location: _____
Have you been seen by a mental health provider before: Yes / No; if yes, with whom and why:
_____
Referred to Better Mood Clinic of South Georgia by and why _____

REASON FOR APPOINTMENT: _____

Depression / Anxiety / Behavioral / Psychological Testing / Legal / Other reason: _____
_____
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? _____
_____
If requesting psychological testing: What's the question you would like answered by the testing?
_____
_____

- If prior psych testing was done: Please bring a copy of previous report; copies of school records / report cards and a written list of all your medications to this appointment!
- Do you have special needs such as: hearing impaired, illiterate or in need of an interpreter?

_____

Are you at risk to yourself or another now? Yes / No; if yes refer to SGMC/Greenleaf (247-4357)
Have you ever harmed yourself? Yes / No; if yes what happened/when: _____
_____
Is there a specific BMC provider you would like to see? _____ Appt Date & Time:_____
All of the Above is true and correct: Patient Signature: _____