BMC Staff Initials: _____

INTAKE INFORMATION **Date: _____**

BETTER MOOD CLINIC OF SOUTH GA, LLC

2935 N ASHLEY ST. BLDG F, VALDOSTA, GA 31602

PATIENT INFORMATION

Legal Name (Last, First, MI): _____ Date of Birth: _____ Age: _____

Name of caller /Relationship to patient: _____ Gender: Male / Female

Relationship Status: Single / Living with Significant Other / Married / Separated / Divorced / Widowed

U.S. Citizen: Yes / No. If no, citizen of what country _____

Identification Number (DoD, Social Security, or Resident Alien Card #): _____

Primary Language Spoken: _____ Interpreter Needed: Yes / No

Military Status: No military history / Active Duty / Separated / Retired

Grade in school/Highest Level of Education: _____ GED / HS / College/Grad / Prof degree

School or Employer _____Job Title _____

Legal Address: _____

Billing Address: _____

Primary Phone Number: _____ (Home/ Cell) OK to call you here: YES / NO

Alternative Phone Number: _____ 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

Name of Policy Holder _____ Primary Insurance Company_____

Insurance ID Number _____ Group Number _____

Effective Date: _____ Deductible: _____ OOP: _____

Network – In / Out Co-Pay: _____ P/A #: _____ # Visits: _____

Name of Secondary Insurance Company: _____

ADDITIONAL INFORMATION

Primary Care Physician: _____ Pharmacy Name /Location: _____

Referred to Better Mood Clinic of South Georgia by: _____

Have you been seen at BMC or any other provider before: Yes / No; if yes, with whom and why: _____

_____

Reason for Appointment: _____

Depression / Anxiety / Behavioral: Other symptoms: _____

_____

How would you rate your symptoms? Mild / Moderate / Severe: Length of concern: _____

Are these concerns affecting 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 Center (247-4357)

History of harming yourself? Yes / No; if yes what happened/when: _____

_____

Do you have a specific provider BMC provider in mind? _____ Appt Date & Time:_____

All of the Above is true and correct: Patient Signature: _____