REGISTRATION / INFORMATION WORKSHEET

CONSENT:

I, _____, give the staff of Palo Verde Behavioral Health permission to perform
(Patient/guardian signature) an assessment and to verify insurance benefits.

PATIENT INFORMATION:

Patient Name: _____ Patient SSN: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

County: _____ e-mail_____

Home Phone #: _____ Cell #: _____ W #: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____ Marital Status: _____

Patient's Occupation: _____ Employer: _____

Employer's Address: _____

Employer's Phone #: _____ Length of Employment: _____

Do you have an Employee Assistance Program? Y or N If YES, Who? _____

Patient's Biological Mother: _____ Patient's Biological Father: _____

EMERGENCY CONTACT INFORMATION:

In Case of Emergency, contact: _____ Phone #: _____

What is their relationship to the Patient? _____

Additional Contact: Name _____ Phone #: _____

What is their relationship to the Patient? _____

REFERRAL INFORMATION:

Who referred you for services at PVBH? _____

What agency are they with (address)? _____