Behavioral Healthcare of Fredericksburg
407 Westwood Office Park, Fredericksburg, VA 22401

ADULT INTAKE

Office use only

Date:_____ Referred by:_____ Dx:

Name:_____

Address:_____ Home/Cell Phone: ( )_____

City, State & Zip _____ Work Phone: ( )_____

Date of Birth_____Gender *Male* *Female* Marital Status *Married* *Single* *Other*

E-Mail:_____

Name, Age and Relationship of Others Living with patient: _____

_____

I am here because: _____

_____

Have you seen any other Mental Health Professional within the past year? *Yes* *No*

Name of Practitioner:_____

Patient Insurance Information

Insurance Company _____

ID #/Group# _____

Primary Name _____

Insured's Address _____
(if same as above,
write same) _____

Insured's Birth date _____ Male Female

Patient's Relationship *Self* *Spouse* *Child* *Other*

Employer _____

If required by my insurer, I have already contacted my insurer and received authorization for services with this office (Circle one) *Yes* *NO*