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

Office use only

Date:_____ Referred by:_____ Dx:

Child's Name:_____ Male Female

Address:_____ Phone: ( )_____

_____ Date of Birth_____

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 # _____

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

Insured's Birth date _____ Male Female

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

Employer _____

Authorization to Treat Minor

I, _____ am the parent and/or Legal Guardian of this Child. I authorize Deborah Jockin, LCSW to evaluate and perform appropriate psychological treatment procedures.

Signature: _____ Date: _____
Patient or Responsible Party