INTAKE – SUNPOINTE HEALTH

Referral Source_______________________________________

Patient's Name: ____ DOB: ____/____/____ Gender: _______

Parent's Name (If under 18) _______________________________________

Pt Address: ____ Phone_________________________________

____ Ok to leave message ☐ Yes ☐ No

Primary Health Ins: _________________________________ Subscriber: ______________________________

Subscribers SS #______-____-_______ DOB: _____________ Subscribers Employer:______________________

POLICY ID # ____ GROUP # ________________________________

MH/BH/Provider Phone # (on back of ins. Card) ____________________________

Secondary Ins. __________________________________ Subscriber: ________________________________

Subscribers SS #:______-______-______ DOB: ___________ Subscribers Employer____________________

Policy ID #____ GROUP # _______________________________

MH/BH/Provider Phone # (on back of ins. Card) _____________________________

Presenting Problems/Symptoms/Diagnosis:

Seeking Counseling ______ Meds______ Testing_____ TMS____

____

____

Relevant Health Problems **D&A Issues (past or present)**

____

Recent Psychiatric Hospitalization? Y / N Where: __________________________

Current Psych Meds: **Other Meds:**

___________________________________ ____

___________________________________ ____

___________________________________ ____