Garland Behavioral Hospital

Patient Information Sheet

Demographics

Patient's Full Name:				Date of Birth:	
Patient's SSN:	Gender:	Race:	Marital Status:	Phone Number:	
Home Address:		City:		State:	Zip:

Employment Information

Patient's Employer:	Occupation:	Work Number:	
Address:	City:	State:	Zip:

Emergency Contact

Emergency Contact:		Relation:	
Home Number:	Work Number:		
Address:	City:	State:	Zip:

Insurance Information

Insurance Company:	Policy Holder's Name:	Relationship:	
Policy Holder's SSN:	Policy Holder's Date of Birth:	Home Number	
Home Address:	City:	State:	Zip:
Employer:	Occupation:	Work Number:	
Address:	City:	State:	Zip

Chief Complaint:

Presenting Problem:		
Are you under the care of a Doctor of Therapist?	Have you been to Garland Behavioral before?	If yes, when?

Who referred you to Garland Behavioral?

☐ Self- Referral ☐ Family Member/Friend ☐ Physician: _____

☐ Other: _____

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