Integrated Behavioral Health Solutions, Inc.

CLIENT INFORMATION PLEASE PRINT

Client's Last Name: _____First: _____Middle Initial:_____

Patient's SS#:_____Date of Birth:_____ Age:_____

Sex: Male Female In School: No Yes if, so Name of School:_____

Primary Diagnosis:_____Secondary diagnosis:_____

Parent(s)/Caregiver(s) Name(s):_____

Relationship to Client:_____

Address:_____Apt#:_____City:_____
State:_____Zip Code:_____

Home
#:_____Cell#:_____Work#:_____

Available via text? No Yes Email Address:_____

Medicaid Member ID# (10 digit):_____

Insurance/Funding Source: MedWaiver, CMS, Other: Specify_____

Insurance I.D.#:

Primary Insurance:_____Secondary Insurance:_____

Is client receiving any other services (circle one)? No Yes, if so, what kind of services:_____

Signature:_____ Date:_____