VALLEY HOSPITAL
MENTAL HEALTH AND CHEMICAL DEPENDENCY CARE

FACE SHEET

DATE_____ TIME _____

Please Complete ALL information

1. Patient Demographics						
Patient Last Name:			First:		Middle:	
Sex: ()M ()F	DOB:	Age:	Marital Status: ()S ()W ()M ()D ()Separated	Ethnic Origin: ()Caucasian ()African-American ()American Indian ()Hispanic ()Asian ()Other		Religion:
Address:			Apt#:	City:	State/Zip:	
Home Phone:	**Cell Phone:**		Social Security #:		Driver's License and State:	
Vehicle Make/Model:			Year:	Color:	License Plate#:	
Employer Name:	Occupation:			Length of Employment:	Employer Phone:	
Employer Address:			Suite#:	City:	State/Zip:	

2. Guarantor/Legal Guardian of Minor:					
Last Name:	First:		Sex: ()M ()F	DOB:	Relation:
Cell Phone:	Social Security#:		M. Initial:	Occupation:	
Address:	Apt #:	City:		State/Zip:	
Employer Name:		Length of Employment:		Employer Phone:	

3. Primary Insurance Information:						
Name of Insurance:			Insurance Phone:			
Policy/Hic#:		Social Security #:		Group Name:		Group#:
Insured's Last Name:	First:		Middle Initial:	Sex: () M ()F	Relation:	DOB:
Employer Name:	Occupation:		Length of Employment:		Employer Phone:	
Employer Address:		Suite#:	City:	State/Zip:		

4. Secondary Insurance: **( )None-Go to Section 5** **( )Yes - Complete Section 4**						
Name of Insurance:			Insurance Phone:			
Policy/Hic#:		Social Security #:		Group Name:		Group#:
Insured's Last Name:	First:		Middle Initial:	Sex: () M ()F	Relation:	DOB:
Employer Name:	Occupation:		Length of Employment:		Employer Phone:	
Employer Address:		Suite#:	City:	State/Zip:		

5. Emergency Contact:

Emergency Contact #1:			Relationship:	
Address:		Apt#:	City:	State/Zip:
Home Phone:	**Cell Phone**:		Work Phone:	
Emergency Contact #2:			Relationship:	
Address:		Apt#:	City:	State/Zip:
Home Phone:	**Cell Phone**:		Work Phone:	

6. Previous Hospitalizations:

Last 12 months: ( )Yes ( ) No	Last 6 months: ( )Yes ( )No
Where:	Where:
When:	When:
Why:	Why:
How long:	How long:

7. Primary Care Doctor:

Name: _____

Address: _____

Phone number: _____

Date of last appointment: _____

Are you willing to sign a Release of Information for this Provider?

☐ YES ☐ NO

8. Therapist/Psychologist

Name: _____

Address: _____

Phone number: _____

Date of last appointment: _____

Are you willing to sign a Release of Information for this Provider?

☐ YES ☐ NO

9. Psychiatrist

Name: _____

Address: _____

Phone number: _____

Date of last appointment: _____

Are you willing to sign a Release of Information for this Provider?

☐ YES ☐ NO

Purpose of disclosure: To identify persons supporting and using services; notification of admission, discharge, and aftercare plans.

All requested information must be completed for insurance claims to be correctly processed. Exclusion of insurance policy information may result in an insurance denial in which you will be totally responsible for your bill. The person who signs consent is the Guarantor/responsible party for this bill. *Revised 8-2012*