

BLUE RIDGE BEHAVIORAL HEALTH SERVICES
170 Thomas Johnson Drive, Suite 200, Frederick, MD 21702

PATIENT INFORMATION - PLEASE PRINT

Today's Date: _____ Home Phone: _____ Date of Birth: _____
Patient's Name _____ Driver's License #: _____
Last First Middle
Address (no PO Boxes please) _____
City _____ State _____ Zip Code _____
Sex M F Social Security # _____ Single Married Divorced Separated Widowed
Patient's Employer _____ Employer Phone: _____
Business Address _____
Name of Person Responsible for Payment _____
Emergency Contact _____ Emergency Phone _____

IF PATIENT IS A MINOR, COMPLETE THE FOLLOWING INFORMATION

SECTION I

Mother/Guardian Name _____ Home Phone: _____
Address (no PO Boxes please) _____
City _____ State _____ Zip Code _____
Date of Birth: _____ Social Security # _____
Guardian Employer _____ Occupation _____
Business Address _____
Business Phone _____

SECTION II

Father/Guardian Name _____ Home Phone: _____
Address (no PO Boxes please) _____
City _____ State _____ Zip Code _____
Date of Birth: _____ Social Security # _____
Patient Employer _____ Occupation _____
Business Address _____
Business Phone _____

INSURANCE INFORMATION

Name of Insured _____
Last First Middle
Insured's Social Security Number _____ Insured's Date of Birth _____
Insured's Policy Number _____ Group Number _____
Relationship to Patient Self Spouse Parent Guardian Other _____
Insured's Address _____
Insured's Employer _____ Business Phone _____
Employer's Address _____
Insurance Company Name _____
Insurance Company Address _____
City _____ State _____ Zip _____
Insurance Company Phone Number _____ Effective Date of Coverage _____