BESTCARE TREATMENT SERVICES FACESHEET

Today's Date

Name:__________ **Birth Name:**__________ **SS#:**__________

Address:__________ **DOB:**__________ **Age:**__________ **Sex:** ☐ **M** ☐ **F**

City:__________ **State:**__________ **Zip:**__________ **County:**__________

Phone Day:__________ **Eve:**__________ **Cell:**__________ **Message:**__________

Email Address:__________

Birthplace:__________ **Drivers License #:**__________ **State:**__________

HOW DID YOU HEAR ABOUT BESTCARE?__________

HAVE YOU EVER BEEN IN SERVICES AT BESTCARE?__________

WHO REFERRED YOU TO BESTCARE TREATMENT SERVICES?

☐ **Self:**__________ ☐ **SCF Worker Name:**__________

☐ **AFS Worker Name:**__________ ☐ **Physician Name:**__________

☐ **Court Evaluator Name:**__________ ☐ **Court:**__________

☐ **P.O. Officer Name:**__________ ☐ **Employer Name:**__________

☐ **School Name and School Representative:**__________

☐ **Other Name:**__________

Address of Referral Source:__________

Phone:__________ **Fax:**__________ **E-Mail:**__________

EMERGENCY CONTACT

Name:__________ **Phone Day:**__________ **Eve:**__________

Address:__________ **City:**__________ **State:**__________ **Zip:**__________

Relationship: ☐ **Mother** ☐ **Father** ☐ **Spouse** ☐ **Sister** ☐ **Brother** ☐ **Friend** ☐ **Other**

HOUSEHOLD MONTHLY GROSS INCOME: YOURS__________ **SPOUSE**__________

HEALTH INSURANCE ☐**YES** ☐ **NONE**

PRIMARY INSURANCE NAME:__________

Effective Date:__________ **Policy Number:**__________ **Insured's ID#:**__________

Insured's Name:__________ **Primary Physician:**__________

Address:__________ **City:**__________ **State/Zip:**__________

Phone:__________ **Secondary Insurance:**__________

Person responsible for bill:__________