INSURANCE/EMPLOYMENT INFORMATION

Complete all information that pertains to you, even if you have no insurance.

Name _____

Name of Primary Care Professional (PCP) _____

PCP Address _____ PCP Phone _____

Gross Monthly Income for Household $ _____

Source(s) of Income (Employment, AFDC, Social Security, Child Support, etc.) _____

# of Dependents (including self) relying on income _____

Employed ☐ No ☐ Yes Employer _____

Start Date _____ Employer Phone _____

Employer Address _____

Are you a student? ☐ No ☐ Yes Are you a high school graduate ☐ No ☐ Yes

Highest grade completed _____ Some college ☐ College Degree ☐

Number of Arrests in the last 30 days _____

Marital Status Single (never married) ☐ Married (spouse in home) ☐ Married (separated) ☐

Divorced ☐ Widowed ☐

Previous Mental Health
(Psychiatric Hospital, general hospital, outpatient, alcohol or drug program, residential, etc.)

_____

_____

Insurance Name (Medicaid, Medicare, private insurance, etc.) _____

Secondary Insurance Name _____

Can you claim Veteran Status ☐ No ☐ Yes

Do you currently use Tobacco ☐ No ☐ Yes Age of first use _____