BIO-BEHAVIORAL MEDICAL CLINICS, INC.
1060 W. Sierra Avenue, Suite 104
Fresno, California 93711
(559) 437-1111 / Fax: (559) 437-1119

EMERGENT ___ **URGENT ___** **ROUTINE ___**

Intake Form

Account #	Date	Authorization #	Number of Visits

Name	Age	Date of Birth	o Male o Female	o Married o Single o Divorced o Widowed

Address	City	State	Zip	Home Phone Number 559-

Social Security Number	Emergency Contact--Nearest Relative	Relationship	Phone Number 559-

Patient's Employer	Work Number 559-	Contact for Appointment	Relationship

Subscriber's Name:	Subscriber's ID#	Subscriber's Date of Birth

Insurance (submit copy of insurance card) Date Verified:	Plan: Group#: Effective Date:	Visits Per Year: Co-Pay– Therapy $__________ Co-Pay – MD $__________

Referred By:	Referral Contact	Phone Number 559-	Fax Number 559-

Address	City	State CA	Zip

Previous Mental Health Treatment o Yes o No Client on Psychotropic Medication o Yes o No	With:	When:

Request Psychiatrist / Therapist	Appt. Date and Time:

DX:

Presenting Problem:

↓BBMC USE ONLY↓ **DISPOSITION** **↓BBMC USE ONLY↓**

1st Call: ___________	Fax to PCP: ______________	1st Call: ____________
2nd Call: ___________	Referred to MD: ___________	2nd Call: ____________
Appt Set: ___________	Referred to TH: ___________	Appt Set: ____________

Therapy Referral To:		
Psychiatric MD Referral To:		