Adult Intake Form

1060 W. Sierra Avenue, Suite 104,
Fresno, CA 93711

Phone: 559. 437. 1117
Fax: 559. 437. 1119

Bio-Behavioral Medical Clinics

○ **Emergent** ○ **Urgent** ○ **Routine**

Type of Referral: ○ MD/NP ○ TH ○ One Time Evaluation

Are you on any type of Disability? ○ Yes ○ No

If yes, what type? ○ Mental Health ○ Medical ○ Dx: ____________

Is this a request for an evaluation for Disability / or continued Disability: ○ Yes ○ No

____ / _____ / _______ Date ____________ Account # ____________ Authorization # ____________ # Visits:

____________ Name ______ Age ___ /____ /________ DOB Sex: ○ F ○ M

____________ SSN# Marital Status: ○ M ○ S ○ D ○ W

____________ Address ________ City ____ State: ______ Zip Code ____________ Primary Contact Phone#

____________ Contact for Appointment ____________ Relationship ____________ Phone#:

Do you require any special accommodation? ○ Yes ○ No Best Number to Call: ____________

If yes, Please Describe: ____________

Subscriber's Name: ____________ Subscriber's ID#: ____________

Subscriber's Date of Birth: ____________ Insurance: ____________ Date Verified: ________

Plan: ____________ Group: ____________ Effective#: ____________

Benefit **MD:** ____________ **TH:** ____________

____________ Referred By ____________ Referral Contact ____________ Phone # ____________ Fax #

Previous Mental Health Treatment: ○Yes ○No *If Yes, Provider / When*: ____________

Inpatient hospitalization for MH within the last 30 days? ○ Yes ○ No *If yes, Date Admitted & Discharged / Where?*: ____________

Are you currently taking medications for: (additional medications write on back)

○ Depression (antidepressants) ○ Psychosis (mood stabilizers) ○ Anti-anxiety (sedatives) ○ADHD ○ Pain Medications

Prescribing Provider: ____________ List of Meds: ____________

○ ADD / ○ ADHD: ____________ Who were you disagnosed by? ____________ PCP / Provider / NP

Request Psychiatrist / NP: ____________ Appt Date & Time: ____________

Request Therapist: ____________ Appt Date & Time: ____________

Client Consent to Mail Appointment Letter: ○ Yes ○ No Additional Notes on Back: ○

Primary Dx: ____________ Other: ____________

Presenting Problem: ____________

BBMC USE ONLY DISPOSITION BBMC USE ONLY

1ST Call: ________ 2nd Call: ________ Appt Set: ________ Fax to PCP: ________

Note: ____________ Initials: ________