MONTEFIORE MEDICAL CENTER/PSYCHIATRY

PATIENT INTAKE FORM

Please Print

PATIENT NAME

Last	First	Initial	SS#
Address		Apt.	Home Phone:
City	State	Zip	Primary Care Physician
			Phone #

Date of Birth ___/___/___ Sex M__ F__

Marital Status S__ M__

Race: White ___ Black ___ Wh / Hispanic ___ Bl / Hispanic ___ Asian ___ Other _____

PATIENT EMPLOYMENT STATUS:

Employed: Y____ N____

Employer's Name _____

Employer's Address

City State Zip

Work Phone # _____

Full Time Student ____

Part Time Student ____

PATIENT RELATIONSHIP TO INSURED

Self _____ Child _____

Spouse ___ Other _____

PATIENT'S CONDITION RELATED TO:

Employment? Y___ N___

Auto Accident? Y___ N___

Other Accident? Y___ N___

PRIMARY INSURANCE

Insured Name:			Medicaid #
Insured Address:			Medicaid Managed Care Name
City:	State:	Zip:	Medicare #
SS#		Phone:	Medicare Managed Care Name
Is Spouse Employed: Y____ N____			Insurance Company
Spouse Date of Birth ___/___/___			Insurance Policy #
Spouse SS# _____			Group Name
			Group #

Does The Patient Have Any Other Health Coverage?

(If Yes, Complete Secondary Insurance Information)

SECONDARY INSURANCE

Other Insured's Name

SS#

Other Insured's Policy Number

Other Insured's Date of Birth

Employer's Name or School Name

Insurance Plan Name or Program Name

Official Use Only

MR # _____

Account # _____

Medicaid Eligible

Yes ____ No ____

BMCO _____

BMCO Phone # _____

PCP Code _____

Health Area _____

Co-Pay Amt. _____

IPA Clinician: _____

I certify that, to my knowledge, this form does not contain any false, misleading, or incomplete information. I also authorize the release of all records or other information which may be necessary to determine the benefits payable to me orassigned by me to the provider of service.

Signature: _____ ***Date:*** _____

UNIVERSITY BEHAVIORAL ASSOCIATES

Montefiore Behavioral Care IPA

RELEASE OF INFORMATION FORM

I _____, authorize Staci Rosenberg LCSW, CEC
(Client Name) (Treatment Practitioner)

to release an initial evaluation summary and progress notes to University Behavioral Associates as is necessary for the authorization, provision and evaluation of the quality of my mental health and/ or substance abuse coverage.

I understand that this consent shall remain in effect for one year or throughout this course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above-named treatment provider and University Behavioral Associates (200 Corporate Drive, Yonkers, N.Y. 10701).

_____ _____
Signature (If minor, signature of parent or guardian **Date**

_____ _____
Witness **Date**