UNIVERSITY BEHAVIORAL HEALTH Denton

FACE SHEET

DATE_____ TIME _____

Please Complete ALL information

1. Patient Demographics						
Patient Last Name:			First:			Middle:
Sex: ()M ()F	DOB:	Age:	Marital Status: ()S ()W ()M ()D ()Separated	Ethnic Origin: ()Caucasian ()African-American ()American Indian ()Hispanic ()Asian ()Other		Religion:
Address:			Apt#:	City:	State/Zip:	
Home Phone:	**Cell Phone:**		Social Security #:		Driver's License and State:	
Vehicle Make/Model:			Year:	Color:	License Plate#:	
Employer Name:	Occupation:			Length of Employment:		Employer Phone:
Employer Address:			Suite#:	City:	State/Zip:	

2. Guarantor/Legal Guardian of Minor:				
Last Name:	First:	Sex: ()M ()F	DOB:	Relation:
Cell Phone:	Social Security#:	M. Initial:	Occupation:	
Employer Name:	Length of Employment:		Employer Phone:	
Employer Address:	Suite#:	City:	State/Zip:	

3. Primary Insurance Information:					
Name of Insurance:			Insurance Phone:		
Policy/Hic#:	Social Security #:		Group Name:		Group#:
Insured's Last Name:	First:	Middle Initial:	Sex: () M ()F	Relation:	DOB:
Employer Name:	Occupation:	Length of Employment:		Employer Phone:	
Employer Address:	Suite#:	City:	State/Zip:		

4. Secondary Insurance: **( )None-Go to Section 5** **( )Yes - Complete Section 4**					
Name of Insurance:			Insurance Phone:		
Policy/Hic#:	Social Security #:		Group Name:		Group#:
Insured's Last Name:	First:	Middle Initial:	Sex: () M ()F	Relation:	DOB:
Employer Name:	Occupation:	Length of Employment:		Employer Phone:	
Employer Address:	Suite#:	City:	State/Zip:		

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5. Emergency Contact:				
Emergency Contact #1:			Relationship:	
Address:	Apt#:		City:	State/Zip:
Home Phone:	**Cell Phone**:		Work Phone:	
Emergency Contact #2:			Relationship:	
Address:	Apt#:		City:	State/Zip:
Home Phone:	**Cell Phone**:		Work Phone:	

6. Previous Hospitalizations:	
Last 12 months: ( )Yes ( ) No	Last 6 months: ( )Yes ( )No
Where:	Where:
When:	When:
Why:	Why:
How long:	How long:

7. How did you hear of University Behavioral Health?
( )Mental Health Professional ( )Legal/Judicial ( )Psychiatrist ( )Clergy/Church ( )Family/Friend ( )Internet ( )Insurance Company ( )Previous UBH Patient ( )Advertisement ( )Organization ( )Other

8. Specific names of individuals/organizations who referred you:	
Name:	Title:
Address:	City:
State:	Zip:
Telephone:	**Permission to contact: ( )Yes ( )No**

School Name:	**School Counselor**:
Address:	City:
State:	Zip:
Telephone:	**Permission to contact: ( )Yes ( )No**

Purpose of disclosure: To identify persons supporting and using services; notification of admission, discharge, and aftercare plans.

All requested information must be completed for insurance claims to be correctly processed. Exclusion of insurance policy information may result in an insurance denial in which you will be totally responsible for your bill. The person who signs consent is the Guarantor/responsible party for this bill. *Revised 12/3/09*