

(Please Print)

DATE: \_\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_\_

SERVICES REQUESTED: \_\_\_\_\_

NAME: \_\_\_\_\_  
(Last) (First) (M.I.) (Birth Last Name)

ADDRESS: \_\_\_\_\_  
(Street Number & Name) (City/State/Zip Code)

PHONE NUMBER: ( ) - \_\_\_\_\_ ( ) - \_\_\_\_\_  
(Home) (Work)

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

MARITAL STATUS:  Single  Married  Divorced  Separated

GENDER: Male  Female  RACE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

COMMENTS: \_\_\_\_\_

**PARENT INFORMATION: Father:**

NAME: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Home)

ADDRESS: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Street) (Work)

\_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(City/State/Zip Code) (Cell)

**PARENT INFORMATION: Mother:**

NAME: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Home)

ADDRESS: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Street) (Work)

\_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(City/State/Zip Code) (Cell)

**COURT APPOINTED LEGAL GUARDIAN?**  Yes  No

If YES, please provide the following information:

NAME: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Home)

ADDRESS: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Street) (Work)

\_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(City/State/Zip Code) (Cell)

**RELATIONSHIP TO PERSON REFERRED:**

**SPECIAL ACCOMMODATIONS NEEDED?**  Yes  No

If YES, please provide the following information:

Physical Disabilities  Yes  No      Hearing:  Yes  No  
Vision  Yes  No      Non-English Speaking:  Yes  No

Other Needs: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

**EMERGENCY CONTACT #1**

NAME: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Home)

ADDRESS: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Street) (Work)

\_\_\_\_\_  
(City/State/Zip Code) PHONE: ( ) - \_\_\_\_\_  
(Cell)

RELATIONSHIP TO PERSON REFERRED: \_\_\_\_\_

**EMERGENCY CONTACT #2**

NAME: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Home)

ADDRESS: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_  
(Street) (Work)

\_\_\_\_\_  
(City/State/Zip Code) PHONE: ( ) - \_\_\_\_\_  
(Cell)

RELATIONSHIP TO PERSON REFERRED: \_\_\_\_\_

**RELATED SERVICES**

Have you, as the person being referred, ever received services from the Barber National Institute/Dr. Gertrude A. Barber Center?  Yes  No

If YES, what services/when? \_\_\_\_\_

Are you receiving services from any other agency at the present time?  Yes  No

If YES, where? \_\_\_\_\_

Type(s) of Services(s): \_\_\_\_\_

**INSURANCE INFORMATION:** Please provide copies of all insurance cards both front & back

PRIMARY INSURANCE COMPANY NAME: \_\_\_\_\_

IDENTIFICATION NUMBER (SSN): \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NAME OF SUBSCRIBER: \_\_\_\_\_ ADDRESS OF SUBSCRIBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

RELATIONSHIP TO PERSON REFERRED: \_\_\_\_\_

SECONDARY INSURANCE COMPANY NAME: \_\_\_\_\_

IDENTIFICATION NUMBER (SSN): \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

NAME OF SUBSCRIBER: \_\_\_\_\_ ADDRESS OF SUBSCRIBER: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

RELATIONSHIP TO PERSON REFERRED: \_\_\_\_\_

MCI #:

MEDICAL ASSISTANCE (or Recipient) NUMBER: \_\_\_\_\_ CARD ISSUE NUMBER: \_\_\_\_\_

PRIMARY CARE PHYSICIAN INFORMATION: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: ( ) - \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street) (City/State/Zip Code)

NAME OF PERSON COMPLETING THIS FORM: \_\_\_\_\_  
(Please Print Name)

SIGNATURE OF PERSON COMPLETING THIS FORM: \_\_\_\_\_