HORIZON BEHAVIORAL HEALTH

ADULT

Patient Information

Patient's Legal Name: Age: DOB:

Street Address: City/State: Zip:

Birth Gender: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female Preferred Name:

Social Security #: Driver's License State and #:

Preferred Phone: Primary Language Spoken:

Is the patient involved in/subject of any active court case to include criminal/custody/divorce: ☐ Yes ☐ No

If yes please explain:

Responsible Party Information

Responsible Party for Bill:

Street Address (if different than patient): City/ State/Zip:

Preferred Phone: Secondary Phone: Email:

Patient Background

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Race – check all that apply**: ☐ American Indian or Alaska Native

☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific islander ☐ White ☐ Other

Are you currently seeing a therapist: ☐ Yes ☐ No If yes: Therapist Name:

Therapist Address: Therapist Phone:

Therapist City, State, Zip Code:

Preferred Pharmacy: Primary/Referring Doctor:

Primary Insurance:

Sponsor Social/Member ID/Subscriber# Group #:

Policy Holder Name: DOB: Relationship to Patient:

Secondary Insurance:

Sponsor Social/Member ID/Subscriber# Group #

Policy Holder Name: DOB: Relationship to Patient:

DO YOU HAVE ANY OTHER HEALTH INSURANCE POLICIES: ☐ Yes ☐ No

****Failure to disclose ALL health insurance policies could result in patient/guardian being responsible for ALL charges in full!***

Signature:_____ Date:_____