INSURANCE/EMPLOYMENT INFORMATION
(Please fill in all information that pertains to you even if you have no insurance)

Name_____

Name of Primary Care Professional_____

*PCP Address*_____*PCP Phone*(____)_____-_____

Gross Monthly Income for Household $_____

Source of income (employment, AFDC, Social Security, Child Support, etc.)_____

Of Dependents (including self) Relying on Income_____

Employed---- YES or NO Employer _____

Start Date_____Employer Address_____

Employer Phone (____) _____-_____

Are you a student? YES NO Are you a high school graduate? YES NO

Highest Grade Completed ____ Some College__ College Degree__

Number of Arrests in the last 30 days _____

Marital Status: Single (never married) ___ Married (spouse in home)___ Married-Separated ____
Divorced ___ Widowed _____

Previous Mental Health
(Psychiatric Hospital, general hospital, outpatient, alcohol or drug program, residential, etc):

_____

_____

Insurance Name (Medicaid, Medicare, private insurance, etc)_____

Secondary Insurance Name_____

Can you claim Veteran status? YES NO

Do you currently use tobacco? YES NO Age at first use _____