Metropolitan Behavioral Services

"Helping you to live in your reality"
4741 Atlantic Blvd. Ste. C Jacksonville, Florida 32207
Phone: 904-562-1391 Fax: 904-374-3057

PATIENT SCREENING INFORMATION

Name: _____ DOB: _____ Age: _____ Sex: M / F
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Social Security Number (For billing purposes only):_____ Marital Status:_____
Employer: _____Work Phone: _____

Spouse/ Parent/ Responsible Party (If other than patient):
Name: _____ Relationship to patient: _____
Employer: _____ Work Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

Medical History:
Have you received any previous/current psychiatric/psychological treatment? No ◯ Yes ◯
If so, please list the reason & provider:_____
_____
_____
Please list any physical illnesses you have been treated for in the last five (5) years:_____
_____
_____
Please list any medications you are taking (Include OTC meds): _____
_____
_____
Please list any allergies: _____
How did you hear about us? _____

Insurance Information:
Name of Insurance Company:_____
Name of Insured/ Subscriber: _____
Date of Birth of insured (if other than the patient): _____ SSN: _____
Policy/ Subscriber/ Member #: _____ Group #: _____
Customer Service/ Provider Services Phone #: _____
Patient Name: _____ Patient DOB: _____

Patient Signature: _____**Date:** _____

Parent/ Legal Guardian Signature: _____ **Date:** _____