After Completion - Please Print Form Before Closing Document

West Bergen Mental Healthcare, Inc.
Application for Treatment Services - Adult

Date: ____ **Name** ____

Date of Birth ____ **Social Security #** ____

Address ____ **City/State/Zip** ____

Home Phone ____ **Cell Phone** ____ **Business Phone** ____

Email ____ **Client's Biological Sex** ☐ Male ☐ Female ☐ Intersex/DSD

Client's Education Level ☐ Elementary ☐ Junior High ☐ High School ☐ Associate's ☐ Bachelor's ☐ Master's ☐ Doctorate ☐ Vocational ☐ GED/High School Equivalency ☐ Some College ☐ Did not complete

Client's Marital Status ☐ Never Married/Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner

Client's Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Client's Race ☐ African American ☐ White ☐ American Indian/Alaskan ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Identified by Two or More

Smoking Status: ☐ Current Smoker ☐ Former Smoker ☐ Never Smoked

Parent/Guardian #1 (If Applicable) ____ Social Security # ____ DOB ____

Address & Phone (If different from above) ____

Parent/Guardian #2 (If Applicable) ____ Social Security # ____ DOB ____

Address & Phone (If different from above) ____

Parents/Guardian Marital Status ____

Please list every member of your household:

Name	Date of Birth	Sex	Ethnicity	Relationship

Insurance Information

Policy Holder's Name ____

Insurance Co. ____ Member ID # ____ Group ID # ____

Who is financially responsible for payment of services? ____

Address and Phone (if different from above) ____

Who is your primary physician?

Name and Address

Are you being treated for any medication condition and/or taking any medication? ☐ Yes ☐ No

if yes please describe

What led you to seek treatment at this time?

How long have you been concerned about what brought you for treatment?

Have you or a family member ever been treated at West Bergen? ☐ Yes ☐ No

if yes by whom and when?

Have you previously consulted with a Mental Health Professional? ☐ Yes ☐ No

if yes by whom and when?

Have you ever been hospitalized for mental health problems? ☐ Yes ☐ No

if yes, where and when?

There may be times when your therapist would consider it important to speak with a family member or friend as part of making a thorough assessment or otherwise supporting your treatment. This communication would take place only with persons whom you designate and with your knowledge and consent.

☐ Yes I would give permission for such communication. (Please sign consent forms)

☐ No, I would prefer not to have any communication concerning my treatment shared with family or friends.

In the event of an emergency, who may we contact?

Name Address Phone

Name Address Phone

We would appreciate it if you wold provide us with any other information that you believe is important to a fuller understanding of you and your circumstances.

Please read and sign below:

I agree that i have completed this form to the best of my ability and any information not included was done so intentionally. I take ful responsibility for disclosing the appropriate insurance information to West Bergen.

Signature: Date: