What LOC is the client seeking?
(check all LOC that apply):

______ASAM 3.1
______OP MH
______OP SA
______MAT

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Face Sheet

Office Use Only:

Consent to chart photo?

Yes: ______ **No:** ______

Name: (first)_______________________________ (m.i.) _________(last)_______________________________________

Current Address: ____

Permanent Mailing Address: ____

Date of Birth: ______________________________ Social Security: ____

Is the place you call "home" safe and supportive of your recovery: ____

Who do you currently live with: ____

Phone: ______________________________ Email: ____

May we... Leave a voicemail? _________ Contact you via text? _________ Contact you via email? _________

Marital Status: _____________________ Sex: ____________ Gender: _________ Pronouns: ________________

Driver's License/ID Number: (if applicable) ____

Employment Status: ____________ Employer: _____________________________ Employer Phone:_______________

Monthly Income: $________________________ Source (select one): ____

Partner/Spouse's Name: ____ Phone: _______________________________

Emergency Contact 1: _________________________ Relationship: ____________ Phone: ______________________

Emergency Contact 2: _________________________ Relationship: ____________ Phone: ______________________

Are you a Veteran? __________________ Combat? ____________________ Which War:________________________

In a few words, please explain the reason for referral, presenting problem(s), intervention(s) attempted, previous

treatment(s), etc.: ____

____

Previous Mental Health Diagnosis: ____

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History of Substances Used: ____

Current Drug of Choice: ______________________________ History of IV Drug Use: ______________________

Allergies: ____

Medical Diagnosis: ____

Current Medications: ____

____

How did you hear about us: ____

Insurance Information

Do you want us to bill your health insurance for services? (select one)

Insurance Name: ____Member ID: _________________________

Is this a Commercial Plan or Maryland Medicaid: ____

Name of Insured (if not you): ______________________________________ DOB: _____________________

Address: ____ Phone: ______________________________

Do you have Medicare? If yes, please provide your Medicare Number: ______________________________

Do you have a Medicare Advantage Plan? If yes, please provide the following:

Insurance Name: ______________________________________ Policy Number: _______________________

Please provide copies of all insurance cards during the referral process or upon admission.

Referred by: ____

Program Name: ____

Referent Email / Phone: ____**Planned D/C Date:** ___________

Patient Signature: ____

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