Psychiatry Admissions Office
600 N. Wolfe Street
Meyer 143

410-955-5104 Office
410-955-6155 Fax

Patient Intake Form

Treatment Program:

☐ Eating Disorder ☐ Geriatric ☐ Mood Disorder ☐ Motivated Behaviors
☐ Pain Treatment ☐ Schizophrenia ☐ Unsure

Demographic Information:

Patient First/Last Name: ________________________________ Date of Birth: ______________

Address: ____

City: _____________________________ State: ____________ Zip: ______________________

Contact Number(s): ____

E-mail Address: ____

Diagnoses: ____

Insurance Information:

Insurance 1

Insurance Name: ____

Subscriber Name: __________________________ Subscriber DOB: __________________________

Member/Policy ID: ________________________ Group Number: __________________________

Mental Health Provider Contact Number for benefits: _____________________________________

Insurance 2

Insurance Name: ____

Subscriber Name: __________________________ Subscriber DOB: __________________________

Member/Policy ID: ________________________ Group Number: __________________________

Mental Health Provider Contact Number for benefits: _____________________________________

Insurance 3

Insurance Name: ____

Subscriber Name: __________________________ Subscriber DOB: __________________________

Member/Policy ID: ________________________ Group Number: __________________________

Mental Health Provider Contact Number for benefits: _____________________________________