

La Amistad Behavioral Health Services
Admission Information Form



Date: _____

Person completing form: _____ Desired Admission Date: _____

Relationship to patient: _____ Organization: _____

Home #: _____ Cell #: _____

Work #: _____ Email: _____

Patient Demographic Information

First name: _____ Middle: _____ Last: _____

Address: _____

DOB: _____ Age: _____ Gender: _____

City, State, Zip: _____ County: _____

Home #: _____ Cell #: _____ SSN: _____

Marital Status: _____

Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Secondary Emergency Contact: _____ Phone #: _____

Relationship to Patient: _____

Children/ Adolescent Only:

Legal/Primary Custodian: _____

Mother's Name: _____ Home #: _____

Address: _____ Cell #: _____

Email: _____ Work #: _____

Employer: _____ Occupation: _____

Father's Name: _____ Home #: _____

Address: _____ Cell #: _____

Email: _____ Work #: _____

Employer: _____ Occupation: _____

Presenting Problems/ Treatment History

List primary issues: _____

Current Diagnosis: _____

Current Medications (list dosages and compliance): _____

Substance Abuse: (include date of last use and amount)	Current	History
	_____	_____
	_____	_____
	_____	_____

Outpatient Providers/ Treatment: (include dates of treatment, IOP, PHP, and group therapy)	Current	History
	_____	_____
	_____	_____
	_____	_____

Inpatient Treatment: (include dates of treatment, detox, acute, and residential)	Recent	History
	_____	_____
	_____	_____
	_____	_____

Significant Medical Issues: (include allergies and special needs)	Current	History
	_____	_____
	_____	_____
	_____	_____

Legal Issues/ Involvement: (include probation, court dates, etc)	Current	History
	_____	_____
	_____	_____
	_____	_____

Insurance Information

Primary

Company Name: _____
Subscriber's Name: _____
Subscriber's SSN: _____
Subscriber's DOB: _____
Subscriber ID#: _____
Group #: _____
Employer: _____
Ins Phone #: _____

Secondary

Company Name: _____
Subscriber's Name: _____
Subscriber's SSN: _____
Subscriber's DOB: _____
Subscriber ID#: _____
Group #: _____
Employer: _____
Ins Phone #: _____

Referral Information

Referred by: _____ Organization: _____
Address: _____ Office #: _____
City, State, Zip: _____ Fax #: _____

INSTRUCTIONS

Please mail or fax your
completed application to:

**La Amistad Behavioral
Health Services
1650 Park Avenue North
Maitland, Florida 32751**

Fax: (407) 637-3068