La Amistad
Behavioral Health Services

Person Completing this form: _____ Admit Date: _____

Relationship to patient: _____ Email address: _____

Home Phone: _____ Cell Phone: _____

Patient Name: First_____Middle_____Last_____

DOB: _____ Age: _____Gender: _____SSN: _____

Address: _____

City, State, Zip _____County: _____

Legal Guardian: _____ Patient Relationship: _____

Mother's Name: _____ Father's Name: _____

Contact Information (if different from above): _____

Presenting Issues/Primary Diagnosis/Need for Treatment:

_____

_____

_____

_____

Current Medications (list dosages and compliance):

_____

_____

_____

_____

_____

La Amistad
Behavioral Health Services

Referred by: _____ Organization: _____

Office Phone: _____ Fax Number: _____

Insurance Information

Primary Policy Name: _____ Phone: _____

Subscriber's Name: _____ DOB _____ SSN: _____

Subscriber's ID#: _____ Group: _____

Employer: _____

Secondary Policy Name: _____ Phone: _____

Subscriber's Name: _____ DOB _____ SSN: _____

Subscriber's ID#: _____ Group: _____

Employer: _____

Please scan and e-mail or fax this completed form to:

La Amistad Behavioral Health Services
Attn: Admission/Intake Team

Fax: 407-637-3069 (or) E-mail to: La Amistad Intake Administration@uhsinc.com