

FACE SHEET

Name: _____ Sex: _____ Date: _____

Home Address: _____

D.O.B.: _____ Place of Birth: _____ Citizenship: _____

Marital Status: _____ Religious Affiliation: _____

Social Security Number: _____ Referral Source: _____

PHYSICAL CHARACTERISTICS:

Height: _____ Weight: _____ Race: _____

Hair Color: _____ Eye Color: _____

FAMILY INFORMATION:

Name: _____ Phone: _____

Address: _____

Emergency Contact: _____ Phone: _____

Address: _____

MEDICAL INFORMATION:

Physician's Name: _____ Phone: _____

Address: _____

Specialist's Name: _____ Phone: _____

Address: _____

Type of Service: _____

MEDICAL CONDITIONS:

Seizure Disorder: _____

Allergies/Physical Restrictions: _____

Other Medical Information/Conditions: _____

FINANCIAL INFORMATION:

Contact Person: _____

Type of Income: SSI _____ SSD _____ SS _____ OTHER _____

Total Monthly Income: _____

Medical Card: _____

Other Insurance: _____ Group #: _____

Contract Number: _____

DAY PROGRAM INFORMATION:

Name of Program: _____

Address: _____

Contact Person: _____ Phone: _____