Welcome

To better serve you, please read and complete this form.

1. Today's Date:

2. Full Name:

3. Do you go by any other names/nicknames:
□ Yes: _____ □ No

4. Date of Birth:

5. Address:

Number & Street/Apt # City: State/Zip:

6. Phone:

7. Email:

8. Formal Diagnosis: _____

9. Substance of choice current or past:
□ Alcohol □ Cocaine □ Crack □ Heroin □ Marijuana
Other: _____

Date of First Substance Used:

Date of Last Use:

10. Referral Information
Referral Reason: _____
Referral Source: □ Self Referral □ Provider □ Other:_____
If provider, please indicate:
Name:_____ Organization:_____ Phone:_____ Email:_____

11. Health Insurance Information (*Check all that apply*):
□ No Health Insurance □ Medicaid/Mass Health □ Medicare
□ Application pending □ Private Insurance Other: _____
□ OT- State Subsidy (*eg. Commonwealth Care, Health Safety Net)*

Insurance Co.: _____ Policy Name: _____
Policy Number: _____ Group #: _____ Policy Start Date: _____