



**TIMBERLAWN MENTAL HEALTH SYSTEM<sup>SM</sup>**  
**PATIENT INFORMATION SHEET**

1. Patient's full name: \_\_\_\_\_ M/F \_\_\_\_\_ DOB \_\_\_\_\_
2. Home address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
3. Phone# \_\_\_\_\_ Marital Status: M S D W (circle one) Race \_\_\_\_\_
4. Patient's Social Security # \_\_\_\_\_
5. Patient's Employer: \_\_\_\_\_ Phone # \_\_\_\_\_ Occupation \_\_\_\_\_
6. Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
7. Next of Kin \_\_\_\_\_ Relation \_\_\_\_\_ Address \_\_\_\_\_
8. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_
9. Emergency Contact: \_\_\_\_\_ Relation \_\_\_\_\_ Address: \_\_\_\_\_
10. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_
11. Insurance Company: \_\_\_\_\_
12. Insured's Name: \_\_\_\_\_ Relationship \_\_\_\_\_
13. Insured's DOB \_\_\_\_\_
14. Social Security # \_\_\_\_\_ Address: \_\_\_\_\_
15. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_
16. Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_
17. Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
18. Presenting Problem: \_\_\_\_\_
19. Are you under the care of Dr. or Therapist? \_\_\_\_\_
20. Has the patient ever been to Timberlawn before? \_\_\_\_\_ If yes, when? \_\_\_\_\_
21. Who referred you to Timberlawn? \_\_\_\_\_
22. Address: \_\_\_\_\_
23. City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_