Kairos COUNSELING

Psychiatric Intake

Patient Name: _____ Preferred Name: _____

Gender: _____ Marital Status: _____SS# _____

Current Address: _____

DOB: _____ Referred By: _____

Caller (if different from patient) _____ Relationship: _____

Best Contact Number: _____ Alt: _____

Email Address: _____

Insurance Name: _____ ID #: _____

Policy Holder: _____ DOB: _____ SS# _____

Address (if other than patient) _____

Phone: _____ Email: _____

Secondary Insurance _____ ID #: _____

Policy Holder: _____ DOB: _____ SS# _____

Address (if other than patient) _____

Phone: _____ Email: _____

Emergency Contact Name: _____

Relationship: _____Phone number: _____

Pharmacy Name: _____

Address: _____

Pharmacy Phone Number: _____

Do you have any questions? _____

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