Mebane Behavioral Health, PC

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Basic Demographic Information

Patient Name: _____ SSN: _____

Billing Address: _____ DOB: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Work Number: _____ Cell Phone: _____

Email address: _____ Gender (Circle): Male Female

If Child/Student: Parent/Guardians Name: _____

Relationship to Child/Student: _____ Phone Number: _____

School Currently Attending: _____ Grade/Year: _____

If Adult: Name of Employer: _____ Occupation: _____

Spouse/Partner's Name: _____

In Case of Emergency Please Notify: Name: _____

Address: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Person Responsible for Payments & Copayments (Policy Holder) If Other Than Patient:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ SSN: _____

Home Number: _____ Work Number: _____ Cell Number: _____

Name of Primary Care Provider: _____

Who Referred You? (If applicable):

Name: _____

Address: _____ Phone Number: _____