New Client Registration Form

*Required Information Fields

Client Information

Date:

*Client Name: *DOB: *SSN: *Gender ☐M ☐F

*Street Address: *City: *Zip Code:

Cell #: Home #: E-mail:

*Insurance Name: Member ID #:

Primary Care Physician (PCP): PCP Phone #: Fax #:

Preferred language: Race: Name of School (if applicable): Grade:

*Briefly describe reason for the referral**:**

Any current and/or recent risk factors (ex. Baker Acts, self-injurious, aggression, arrest, substance use, elopement (if so, please briefly describe:

*Is the client currently receiving any mental health services**?** ☐No ☐Yes – if yes, where:
Please describe:

Parent/Caregiver Information (*if not above client)*

(Note: If NOT biological parent, court guardianship paperwork MUST accompany this Registration Form)

Name: Cell or Home Phone #: E-mail:

Relationship to Client: ☐ Bio-Parent ☐ Adoptive ☐ Relative ☐ Non-Relative ☐ Foster Parent ☐ Other

Placement Type (if applicable): ☐ Parent/Caregiver ☐ Group Home ☐ Shelter ☐ Other

*****Permission to send text message appointment reminder to client or guardian ☐Yes ☐No

Referral Source (*if applicable)*

Agency Name:

Name: Cell #: E-Mail:

Supervisor Name: Cell #: E-Mail:

Name of Community Based Care Organization (CBC), if applicable:

Services Requested (check all that are applicable)

☐ Mental Health Assessment ☐ Individual Counseling ☐ Family Counseling ☐ Therapeutic Visitation ☐ TCM
☐ Substance Abuse ***(Lakeland Only)*** ☐ Psychiatry (THERAPY CLIENTS ONLY)

E-mail this form to referral@familiesfirstfl.com or fax us as follows:

***Lakeland - 863-583-0392 * Ocala - 352-354-9166 * Orlando - 407-386-7429**
***Panama City/Tallahassee - 850-290-7442 *Tampa - 813-435-2033**

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