Client ID: _____

Face Sheet/ Form 890.B

Consumer Name: (Last) _____(First) _____(MI) _____

Date of Admission: _____ Insurance # _____

Social Security #: _____ Date of Birth: _____ Gender _____

Street Address: _____

City: _____ State: _____ County: _____

Phone: _____ Other Phone: _____

Parent/Legal Guardian: _____ Phone: _____

Marital Status: _____

Name of Authorized Representative: _____ Phone: _____

Address: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Psychiatrist: _____ Phone: _____

Address: _____

Emergency Contacts:

#1: Name: _____ Relationship: _____ Phone: _____

Address: _____

#2 Name: _____ Relationship: _____ Phone: _____

Address: _____

History of Drug/Alcohol Abuse: _____

Common Problems: _____

Allergies/Adverse Reactions (include food and medication and dietary restrictions):

Medications (Prescription and OTC) (As of date of this Face Sheet) (Please contact physicians listed on page 1 of this form for current information.)
Significant Medical Problems:
Ambulatory or sensory problems:
Significant communication problems: Adjudicated Legal Incompetency or Legal Incapacity if applicable: **Staff Signature**: _____**Date**_____

Updated 2/23/18