



## Welcome

**To better serve you, please read and complete this form**

**Phone Number:** (617) 684-6209

**Fax Number:** (617) 249- 0480

**Email:** familiasoutpatientintake@casaesperanza.org

<b>1. Today's Date:</b> _____		
<b>2. Full Name:</b> _____	<b>3. Do you go by any other names/nicknames:</b> <input type="checkbox"/> Yes: _____ <input type="checkbox"/> No	
<b>4. Date of Birth:</b> _____		
<b>5. Address:</b>		
Number & Street/Apt # _____	City: _____	State/Zip: _____
<b>6. Phone:</b> _____	<b>7. Email:</b> _____	
<b>8. Mental Health Diagnosis:</b> _____		
<b>9. Language Capacity:</b> _____		
<b>10. Substance of choice current or past:</b> <input type="checkbox"/> Alcohol <input type="checkbox"/> Cocaine <input type="checkbox"/> Crack <input type="checkbox"/> Heroin <input type="checkbox"/> Marijuana Other: _____	Date of First Substance Used: _____	Date of Last Use: _____
<b>11. Referral Information</b>		
Referral Reason: _____		
Referral Source: <input type="checkbox"/> Self Referral <input type="checkbox"/> Provider <input type="checkbox"/> Other: _____		
<i>If provider, please indicate:</i>		
Name: _____ Organization: _____ Phone: _____ Email: _____		
<b>12. Health Insurance Information (Check all that apply):</b>		
<input type="checkbox"/> No Health Insurance <input type="checkbox"/> Medicaid/Mass Health ( <i>Indicate Health Insurance Plan</i> ): _____		
<input type="checkbox"/> Application Pending <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicare		
<input type="checkbox"/> OT- State Subsidy ( <i>eg. Commonwealth Care, Health Safety Net</i> ) <input type="checkbox"/> Other: _____		
Insurance Co.: _____		Policy Name: _____
Policy Number: _____	Group #: _____	Policy Start Date: _____