PERSONAL AND HEALTH-RELATED INFORMATION

FACILITY NAME: _____ **DATE:** _____

DJJID #_____

YOUTH'S PERSONAL INFORMATION

NAME OF YOUTH: _____ _____ _____
First Middle Last

Youth First Alias: _____

Date of Birth: _____ Age: _____ Eyes: _____ Hair: _____

Race: _____ Religious Preference: _____

Youth Address: _____ _____ _____ _____ _____
Street Address City State Zip Code County

Telephone # (home): _____ Telephone # (mobile): _____

School Information: _____ _____ _____ Grade completed: _____
School Name City/State County

PARENT/GUARDIAN INFORMATION

Name of Parent/Guardian_____ _____ _____ _____
First Middle Last Relationship

Address: _____ _____ _____ _____ _____
Street Address City State Zip Code County

Telephone # (home): _____ Telephone # (mobile): _____

HEALTH CARE PROVIDER INFORMATION

Physician

Name of Primary Care Physician: _____ _____
First Last

Address: _____ _____ _____ _____
Street Address City State Zip Code

Telephone # (office): _____ Telephone # (mobile/pager): _____

Specialist

Specialist Name: _____ _____ _____
First Last Specialty

Address: _____ _____ _____ _____
Street Address City State Zip Code

Telephone # (office): _____ Telephone # (mobile/pager): _____

Dentist

Dentist Name: _____ _____
First Last

Address: _____ _____ _____ _____
Street Address City State Zip Code

Telephone # (office): _____ Telephone # (mobile/pager): _____

MENTAL HEALTH PROVIDER INFORMATION

Provider Name: _____ _____ _____
First Last Title

Address: _____ _____ _____ _____
Street Address City State Zip Code

Telephone # (office): _____ Telephone # (mobile/pager): _____

COMMUNITY HEALTH PROVIDERS INFORMATION

Preferred Hospital: _____ Last inpatient stay: _____
Date

Preferred Mental Health Facility: _____ Last inpatient stay: _____
Date

County Health Department: _____ _____ _____
Name County State

HEALTH INSURANCE INFORMATION

☐ **NONE**

Insurance Company: _____
Name of Company

Insurance Address: _____ _____ _____ _____
Street Address City State Zip code

Telephone Number: _____
(Area code) number

Policy Information: _____ _____ _____ _____
Insured Name Insured SSN Insured DOB Relationship

_____ _____ _____
Insurance ID # Policy # Group #

NOTE: PLEASE PROVIDE A COPY OF INSURANCE CARD TO FILE IN INDIVIDUAL HEALTH CARE RECORD.

MEDICAID INSURANCE INFORMATION

☐ **NOT APPLICABLE**

Identification Number: _____ _____
State Medicaid Number State

_____ _____
Name of Medicaid Program Case Manager Name

CASE CONTACTS

_____ _____ _____
Juvenile Probation Officer Unit Phone: Work and Mobile