

G-Pin \_\_\_\_\_  
I-Pin \_\_\_\_\_  
Contract# \_\_\_\_\_  
F Sched: \_\_\_\_\_

# BEHAVIORAL HEALTHCARE OPTIONS PROVIDER DATA SHEET

*\* Please PRINT LEGIBLY with black or blue ink ONLY*

Name: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ License #: \_\_\_\_\_

Specialty: \_\_\_\_\_ Board Certified: \_\_\_ Yes \_\_\_ No

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_ DEA #: \_\_\_\_\_

Practice Group Name: \_\_\_\_\_

**SITE** Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is this **SITE** a private residence: \_\_\_ Yes \_\_\_ No Hours: \_\_\_\_\_

**MAIL/BILL** Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Is this **MAIL/BILL** a private residence: \_\_\_ Yes \_\_\_ No Is it a Billing Company: \_\_\_ Yes \_\_\_ No

## Patient Information:

*Please answer as many questions as possible.*

Age Range:

\_\_\_ Pediatric (12 and under) \_\_\_ Adolescents (13-18) \_\_\_ Adults (18-64) \_\_\_ Geriatrics (65+)

Limitations: \_\_\_\_\_

Services Provided: *Check all that apply*

<input type="checkbox"/> Abuse	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Schizophrenia	<b>Other:</b>
<input type="checkbox"/> Adjustment Disorder	<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Major Depression	<input type="checkbox"/> Sexual Abuse	_____
<input type="checkbox"/> Adjustment Reaction	<input type="checkbox"/> Codependency	<input type="checkbox"/> Mood	<input type="checkbox"/> Sexual Abuse/Child	_____
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Couples	<input type="checkbox"/> OCD	<input type="checkbox"/> Sleep Disorders	_____
<input type="checkbox"/> Alcohol	<input type="checkbox"/> Crime Victims	<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> Stress	_____
<input type="checkbox"/> Anger	<input type="checkbox"/> Disassociation	<input type="checkbox"/> Phobias	<input type="checkbox"/> Trauma	_____
<input type="checkbox"/> ADD w/Hyperactivity	<input type="checkbox"/> Fears	<input type="checkbox"/> Post Traumatic Stress Disorder	<input type="checkbox"/> Cultural Sensitivity: (Specify:)	_____
<input type="checkbox"/> ADD w/o Hyperactivity	<input type="checkbox"/> Grief/Death/Loss	<input type="checkbox"/> Psychosis	_____	_____

Languages: \_\_\_ Spanish \_\_\_ French \_\_\_ Sign Language \_\_\_ Other(s): \_\_\_\_\_

Ethnicity \_\_\_ African American \_\_\_ Caucasian Gender \_\_\_ Female  
(voluntary) \_\_\_ Hispanic \_\_\_ Asian Other \_\_\_\_\_ (voluntary) \_\_\_ Male

Hospital Privileges: \_\_\_\_\_

Practice Limitations: \_\_\_\_\_

Certifications/Training: \_\_\_\_\_

**\*\* Please attach separate sheet should the boxes above not provide enough space \*\***