

NEW PATIENT INFORMATION FORM For Referrals to Outpatient Therapy

LAST NAME	FIRST NAME	M.I
<input type="text"/>	<input type="text"/>	<input type="text"/>

ADDRESS

CITY	STATE	ZIP CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>

TELEPHONE (HOME)	TELEPHONE (MOBILE)	SOCIAL SECURITY #
<input type="text"/>	<input type="text"/>	<input type="text"/>

DATE OF BIRTH	GENDER	RACE	LANGUAGE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

BIRTH PLACE	<input type="checkbox"/> CITIZEN <input type="checkbox"/> RESIDENT <input type="checkbox"/> UNDOCUMENTED	MOTHER'S MAIDEN NAME
<input type="text"/>		<input type="text"/>

MARITAL STATUS	NAME OF SPOUSE
<input type="text"/>	<input type="text"/>

EMERGENCY CONTACT NAME	RELATIONSHIP
<input type="text"/>	<input type="text"/>

ADDRESS	TELEPHONE NUMBER
<input type="text"/>	<input type="text"/>

INSURANCE:

<input type="checkbox"/> MEDI-CAL #	MEDI-CAL ISSUE DATE	<input type="checkbox"/> MEDICARE #
<input type="text"/>	<input type="text"/>	<input type="text"/>

OTHER INSURANCE

Please return this form and the MD Referral form to:

Rancho Outpatient Therapy Office

Telephone: (562) 385-7111, ext.56536 Fax: (562) 385-7826

Email: OutpatientTherapy@dhs.lacounty.gov (please send encrypted)