Brooks TLC Hospital System
Inpatient Chemical Dependency
845 RT 5&20 Main Road
Irving, NY 14081

Patient Information: **LOCADTR #** _____

Last Name: _____ First Name: _____ Date: _____

Street: _____ City: _____ State: _____

Zip: _____ County: _____ DOB: _____ Sex: Male/Female

Race: _____ Marital Status: _____ Telephone #: _____

SSN: _____ Emergency Contact: _____

Phone Number: _____ Relationship: _____

Referral Source: _____

Contact Person: _____ Phone Number: _____

Mandated To TX: Yes/No Court: _____

Contact Person: _____ Phone Number: _____

Diagnosis: _____

Last Use: _____ Alcohol: _____ Other Drug: _____

Type of Drug: _____

Inpatient/Outpatient Treatment: Yes/No Where: _____

Counselor: _____ Phone Number: _____

Employed: Yes/No Employer Name: _____

Address: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Address: _____

Pharmacy Information:

Pharmacy:_____ Phone Number:_____

Address:_____

Primary Insurance:

Insurance Name:_____ Policy Number:_____

Group Number:_____ Plan Code #: _____

If patient is not the subscriber - Name : _____ Phone: _____

Address: _____ Relationship: _____

Date of birth: _____ SS# _____

Secondary Insurance:

Insurance Name:_____ Policy Number:_____

Group Number:_____ Plan Code #: _____

Insurance verified through: HEALTHENET/EPACES/MY ABILITY/UNITED HEALTH CARE/PHONE

Insurance Verified: Yes/ No Prior Authorization Needed: Yes/No

Authorization Number: _____ Contact Person:_____

Insurance Number:_____ Fax Number:_____

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____