Cypress Creek Hospital **Admission Information Form**

Date_____

Person completing form:_____ Desired Admission Date:_____

Relationship to patient:_____ Organization:_____

Home #:_____ Cell #_____

Work #:_____ Email:_____

Patient Demographic Information

First name:_____ Middle:_____ Last:_____

Address:_____

City, State, Zip:_____ County:_____

DOB:_____ Age:_____ Gender_____

Home #:_____ Cell #:_____ SSN:_____

Marital status:_____

Emergency Contact:_____ Phone #:_____

Relationship to patient:_____

Secondary emergency contact:_____ Phone #:_____

Relationship to patient:_____

Children/Adolescent Only

Legal/Primary Custodian:_____ Phone #_____

Mother's name:_____Home #:_____ Cell #:_____

Work #_____ Email:_____

Address:_____

Employer_____ Occupation:_____

Father's name:_____Home #:_____ Cell #:_____

Work #_____ Email:_____

Address:_____

Employer_____ Occupation:_____

Insurance Information

Primary	**Secondary**
Company Name:_____	Company Name:_____
Subscriber's Name:_____	Subscriber's Name:_____
SSN:_____	SSN:_____
DOB:_____	DOB:_____
Group #:_____	Group #:_____
Employer:_____	Employer:_____
Ins Phone #:_____	Ins Phone #:_____

Referral Information

Referred by:_____ Organization:_____

Address:_____ City, State, Zip:_____

Office:_____ Fax #:_____

Presenting Problems/ Treatment History

List primary issues:_____
_____
_____
_____

Current Diagnosis:_____

Attending Physician_____ Phone #_____

Current Medications (list dosages and compliance):_____
_____
_____
_____

Substance Abuse	Current	History
(include date of last use and amount)	_____	_____
	_____	_____
	_____	_____
Outpatient Providers/Treatment		
(include dates of treatment, IOP,	_____	_____
PHP and group therapy)	_____	_____
	_____	_____
Inpatient Treatment		
(include dates of treatment, detox	_____	_____
acute and residential)	_____	_____
	_____	_____
Significant Medical Issues		
(include allergies and special needs)	_____	_____
	_____	_____
	_____	_____