PLEASE USE BLACK OR BLUE INK , NO PENCILS OR OTHER COLORED INK PENS

IF YOU REQUIRE ASSISTANCE FILLING OUT FORMS PLEASE LET THE RECEPTIONIST KNOW

SOLACE
CRISIS TREATMENT CENTER
6601 Valentine Way, Santa Fe NM 87507
Phone: (505) 988-1951 Fax: (505) 988-1906

Face Sheet

Name of person filling out form: _____

Client's Name: _____ Today's Date: _____

Date of Birth _____ Age: _____ Sex at Birth: _____ Gender Identity:_____

Your Address:_____

Your Phone Number: _____ OK to leave message? Y / N

Medicaid: Y / N _____ Other Health Insurance: Y / N:_____

Social Security number: _____

School:_____ Grade: _____

Emergency Contact: **(Required)**_____

Name Phone Number

Ethnicity (check one)

___ Hispanic ___ White ___ Native American ___Alaskan Native

___ Black/African ___ Asian Pacific Islander ___ Unknown ___ Other

Parent / Legal Guardian's Information

Responsible Adult(s): 1)_____ 2) _____

Name Name

Relationship(s) to Child: 1) _____ 2) _____

Legal custody of Child: Yes / No / Shared Yes / No / Shared

Address: 1) _____ 2) _____

Street Street

1) _____ 2) _____

City City

1) _____ 2) _____

State Zip State Zip

Home Phone #: 1)_____ 2) _____

May we leave messages? Yes / No Yes / No

Cell Phone #: 1)_____ 2) _____

May we leave messages? Yes / No Yes / No