Urgent Behavioral Health Care

311 Camden Suite #510
San Antonio, Texas 78215
Ph (210) 591-1615 Fax (210) 591-1635

Date: _____

Demographic Information: This form needs to be filled out completely.

First Name:_____ Last Name:_____

Address:_____

City:_____ State: _____ Zip Code:_____

DOB:_____/_____/_____

Home Phone:(_____)_____

Cell Phone:(_____)_____

Email:_____@_____

Preferred method of contact: ☐ home phone ☐ cell phone ☐ email

Emergency Contact: _____ Relationship: _____

Phone number: (_____)_____

Pharmacy: _____ Phone#: _____

Employment/Insurance Information:

Name of Employer:_____

Work Address:_____

City:_____ State:_____ Zip Code:_____

Work:(_____)_____

Name of Primary Insurance: _____Policy #: _____

Policy Holder Name: _____Relationship_____

DOB of Policy Holder: _____

Name of Secondary Insurance: _____Policy #:_____

Policy Holder Name: _____ Relationship _____

DOB of Policy Holder: _____

Primary Care Provider: (Please complete release of information)

Name:_____

Phone:(____)_____ Fax: (____)_____

Clinical Information: I want to see: ☐ Counselor ☐ Psychiatrist ☐ Both

Reason for visit:

_____

_____

Email Form

*If the email form button does not work on your system please manually attached the pdf files and email to UBHC@UrgentBehavioralHealthCare.com.