



# FERNBROOK Family Center

2575 Harvest Lane NW, P.O. Box 977, Owatonna, MN, 55060  
Phone: (507) 446-0431 Fax: (651) 925-0337 Email: info@fernbrook.org

## Intake/Registration (Child)

Please attach signed release form and copy of current diagnostic.

Eligible Child: \_\_\_\_\_ DOB: \_\_\_\_\_

Address): \_\_\_\_\_

Mother: \_\_\_\_\_ Father: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

DOB: \_\_\_\_\_

Significant other: \_\_\_\_\_

### Siblings and household members:

Name	Age/DOB	Living in the home
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency contact name and phone: \_\_\_\_\_

Culture/Ethnicity: \_\_\_\_\_ Primary Language: \_\_\_\_\_

MA Number: \_\_\_\_\_ SS Number: \_\_\_\_\_

Axis I: \_\_\_\_\_

Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_

Meds: \_\_\_\_\_

Allergies: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Therapist: \_\_\_\_\_ Phone: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_ Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

County Pay: Yes      No

County: \_\_\_\_\_

MA: Yes      No

Other Agencies:

Contact Name	Clinic & Address	Phone
<b>SCHOOL</b> - _____	_____	_____
_____	_____	_____
_____	_____	_____

INS Company Name: \_\_\_\_\_

INS Company Phone: \_\_\_\_\_

ID Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_

Subscriber Address: \_\_\_\_\_

Referral Name and Source: \_\_\_\_\_

Date: \_\_\_\_\_

Person completing form: \_\_\_\_\_

Reason for Referral: