Capitol _____ Date Entered _____ Initials _____

C.O.R.E. Medical Clinic, Inc.
PRE-ADMISSION SCREENING SHEET

How were you referred to C.O.R.E. Medical Clinic, Inc.? Today's Date _____

☐ Phone Book ☐ Primary Care Physician ☐ Another physician ☐ Psychiatrist/therapist/counselor

☐ **www.naabt.com** website ☐ **www.coremedicalclinic.com** website ☐ I was a previous patient at C.O.R.E. Medical

☐ From current or previous patient ☐ Other (please list) _____

PATIENT INFORMATION Patient ID _____ Counselor ID _____

Patient Name (L, F, MI) _____ Alias _____ DOB _____

Social Security # _____ Insurance Carrier _____

Hair Color _____ Eye Color _____ Age _____ Ethnicity _____ Weight _____

Street _____ City _____ ST _____ ZIP _____

Nearest Cross Street _____ Medi-Cal # _____

Home Phone _____ Work Phone _____ Message/Cell Phone _____

HISTORY (not required)

Name of Clinic _____ Consent Signed _____

Date Faxed _____ Hx Received Yes ☐ No ☐

For Previously Treated Buprenorphine Patient:

OLD ID# _____ Date Chart Ordered _____ By _____

FISCAL

Private Pay: 1st Month's fees	☐ $500 new admit	☐ $350 returning bup pt.	☐ $250 methadone transfer	☐ $350 direct bup transfer	Paid: Y ☐ N ☐

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice.

Patient Signature: _____ **Date:** _____

APPOINTMENT DATE: _____ **TIME:** _____