CONSUMER INFORMATION FACE SHEET

Name: | Medi-Cal #:

Date of Birth: | Medi-Care #

UCI #: | Other Insurance:

SSN:

CONTACT INFORMATION:

Placing Agency:

Counselor: | **Name:**

Address: | Address:

Telephone: | Telephone:

Name: | **Name:**

Address: | Address:

Telephone: | Telephone:

MEDICAL PROVIDERS:

Primary Physician: | **Dentist:**

Address: | Address:

Telephone: | Telephone:

Pharmacy: | **Other:**

Address: | Address:

Telephone: | Telephone:

CONSUMER INFORMATION

Diagnosis: | Ambulatory Status:

Language Spoken: | Marital Status:

Religious Preferences: | Legal Status:

Burial Plan:

Allergies:

Eye Color:

Height:

Identifying Marks:

Photograph Date: