



**PERSONAL AND HEALTH-RELATED INFORMATION**

**FACILITY NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DJJID #** \_\_\_\_\_

**YOUTH'S PERSONAL INFORMATION**

**NAME OF YOUTH:** \_\_\_\_\_  
First Middle Last

Youth First Alias: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Eyes: \_\_\_\_\_ Hair: \_\_\_\_\_

Race: \_\_\_\_\_ Religious Preference: \_\_\_\_\_

Youth Address: \_\_\_\_\_  
Street Address City State Zip Code County

Telephone # (home): \_\_\_\_\_ Telephone # (mobile): \_\_\_\_\_

School Information: \_\_\_\_\_  
School Name City/State County Grade completed: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Name of Parent/Guardian \_\_\_\_\_  
First Middle Last Relationship

Address: \_\_\_\_\_  
Street Address City State Zip Code County

Telephone # (home): \_\_\_\_\_ Telephone # (mobile): \_\_\_\_\_

**HEALTH CARE PROVIDER INFORMATION**

**Physician**

Name of Primary Care Physician: \_\_\_\_\_  
First Last

Address: \_\_\_\_\_  
Street Address City State Zip Code

Telephone # (office): \_\_\_\_\_ Telephone # (mobile/pager): \_\_\_\_\_

**Specialist**

Specialist Name: \_\_\_\_\_  
First Last Specialty

Address: \_\_\_\_\_  
Street Address City State Zip Code

Telephone # (office): \_\_\_\_\_ Telephone # (mobile/pager): \_\_\_\_\_



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

**Dentist**

Dentist Name: \_\_\_\_\_

First Last

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

Street Address City State Zip Code

Telephone # (office): \_\_\_\_\_ Telephone # (mobile/pager): \_\_\_\_\_

**MENTAL HEALTH PROVIDER INFORMATION**

Provider Name: \_\_\_\_\_

First Last Title

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

Street Address City State Zip Code

Telephone # (office): \_\_\_\_\_ Telephone # (mobile/pager): \_\_\_\_\_

**COMMUNITY HEALTH PROVIDERS INFORMATION**

Preferred Hospital: \_\_\_\_\_ Last inpatient stay: \_\_\_\_\_

Date

Preferred Mental Health Facility: \_\_\_\_\_ Last inpatient stay: \_\_\_\_\_

Date

County Health Department: \_\_\_\_\_

Name County State

**HEALTH INSURANCE INFORMATION**

**NONE**

Insurance Company: \_\_\_\_\_

Name of Company

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

Street Address City State Zip code

Telephone Number: \_\_\_\_\_

(Area code) number

Policy Information: \_\_\_\_\_

Insured Name Insured SSN Insured DOB Relationship

Insurance ID # Policy # Group #

**NOTE: PLEASE PROVIDE A COPY OF INSURANCE CARD TO FILE IN INDIVIDUAL HEALTH CARE RECORD.**

**MEDICAID INSURANCE INFORMATION**

**NOT APPLICABLE**

Identification Number: \_\_\_\_\_

State Medicaid Number State

Name of Medicaid Program Case Manager Name

**CASE CONTACTS**

Juvenile Probation Officer

Unit

Phone: Work and Mobile

