South Community Inc.

CLIENT REGISTRATION FORM

Client Legal First Name:	**Middle**	**Last Name:**

Client ID #	**Date of Birth:**	**Age:**

Race: (Check All that Apply)
☐ W=White ☐ B=Black/African American ☐ M=Alaskan Native
☐ N=Native American ☐ A=Asian ☐ Multiple Race or Unknown
☐ P=Native Hawaiian/Other Pacific Islander/Middle Eastern

Ethnicity: ☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Hispanic ☐ Not Hispanic

Address:

City:	**State:**	**Zip:**	**County of Residence:**
Home Phone:	**Cell:**	**Work Phone:**	**Extension**
Client Grade: _____	**Education Type:___ (Regular, SED(formerly SBH), LD, HI, VI, MH, DD, OH, Other)**	**Sex:** ☐ M ☐ F	**Primary Language:**

Social Security Number:

Are you a Veteran? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Are you a US Citizen? ☐ Yes ☐ No

Do you want to work? ☐ Yes ☐ No
(If Yes, Staff send referral to Supported Employment)

How did you hear about us? ☐ Dr. ☐ Insurance Co. ☐ Hospital ☐ Family ☐ Friend ☐ Close to Home ☐ Google ☐ Other

Emergency Contact Name:	**Relationship:**	**Phone Number:**
Name of Parent/Legal Guardian		**Address**

Home Phone:	**Cell:**	**Work:**
EAP Eligible - Company Name		**Number of Visits:**

Household/Financial Information

Family Size/Dependents	**Gross Monthly Income:**

INSURANCE INFORMATION (Please provide insurance card)

Name of Primary Insurance:	**Subscriber ID (Policy #):**	**Group #:**
Subscriber Name:	**Subscriber SSN:**	**Subscriber's Date of Birth:**

Patient Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other _____

Name of Secondary Insurance:	**Subscriber ID (Policy #):**	**Group #:**	
Subscribers Name:	**Subscriber SSN:**	**Date of Birth of Subscriber**	

Patient Relationship to Subscriber:
☐ Self ☐ Spouse ☐ Child ☐ Other _____

Do you have a Living Will or Advanced Directive? ☐ Yes (Obtain Copy for Chart) ☐ No (Offer Packet) ☐ No (Declined)

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to South Community. I understand that I am financially responsible for any balance. I also authorize South Community or the insurance company to release any information required to process my claims.

Client/Legal Guardian Signature:	**Date:**