South Community Inc.

CLIENT REGISTRATION FORM

Client Legal First Name:	Preferred Name:	Middle	Last Name:	Pronouns:

Client ID #	Date of Birth:	Age:	Social Security Number:

Address:	E-Mail Address:

City:	State:	Zip:	County of Residence
Home Phone:	Cell:	Work Phone:	Extension

Emergency Contact Name:	Relationship:	Phone Number:

How do you describe your race? _____
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
How do you describe your Ethnicity? _____

Client Grade: ________

Education Type:___ (Regular, SED(formerly SBH), LD, HI, VI, MH, DD, OH, Other)

Sex: ☐ M ☐ F
What is your assigned sex? _____
How do you describe your gender? _____

Primary Language:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner
Name of person in meaningful relationship: _____

Are you a Veteran? ☐ Yes ☐ No

Are you interested in employment supports that may assist you with obtaining or maintaining employment through our Supported Employment Program?
☐ Yes ☐ No ☐ Not now, but I may ask about this in the future
(If Yes, Staff send referral to Supported Employment)

Are you a US Citizen? ☐ Yes ☐ No

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

Name of Parent/Legal Guardian	Address

Home Phone:	Cell:	Work:

EAP Eligible - Company Name:	Relationship to EAP Covered Individual: ☐ Employee ☐ Family Member	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? ☐ Yes – Request copy for Chart ☐ No
Do you have an Advanced Directive? ☐ Yes (Obtain Copy for Chart) ☐ No (Offer Packet – Contact Quality) ☐ 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: