

## 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) <input type="checkbox"/> W=White <input type="checkbox"/> B=Black/African American <input type="checkbox"/> M=Alaskan Native <input type="checkbox"/> N=Native American <input type="checkbox"/> A=Asian <input type="checkbox"/> Multiple Race or Unknown <input type="checkbox"/> P=Native Hawaiian/Other Pacific Islander/Middle Eastern						Ethnicity: <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Mexican <input type="checkbox"/> Cuban <input type="checkbox"/> Other Hispanic <input type="checkbox"/> Not Hispanic How do you describe your Ethnicity? _____						
Client Grade:		Education Type: (Regular, SED(formerly SBH), LD, HI, VI, MH, DD, OH, Other)				Sex: <input type="checkbox"/> M <input type="checkbox"/> F What is your assigned sex? _____ How do you describe your gender? _____			Primary Language:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Partner Name of person in meaningful relationship: _____						Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Are you interested in employment supports that may assist you with obtaining or maintaining employment through our Supported Employment Program? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not now, but I may ask about this in the future (If Yes, Staff send referral to Supported Employment)						Are you a US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No						
How did you hear about us? <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Hospital <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Close to Home <input type="checkbox"/> Google <input type="checkbox"/> Other												
Name of Parent/Legal Guardian:						Address:						
Home Phone:			Cell:			Work:						
EAP Eligible - Company Name:				Relationship to EAP Covered Individual: <input type="checkbox"/> Employee <input type="checkbox"/> Family Member				Number of Visits:				
<b>Household/Financial Information</b>												
Family Size/Dependents						Gross Monthly Income:						
<b>INSURANCE INFORMATION (Please provide insurance card)</b>												
Name of Primary Insurance:				Subscriber ID (Policy #):				Group #:				
Subscriber Name:				Subscriber SSN:				Subscriber's Date of Birth:				
Patient Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____												
Name of Secondary Insurance:				Subscriber ID (Policy #):				Group #:				
Subscribers Name:				Subscriber SSN:				Date of Birth of Subscriber:				
Patient Relationship to Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other												
Do you have a Living Will? <input type="checkbox"/> Yes – Request copy for Chart <input type="checkbox"/> No Do you have an Advanced Directive? <input type="checkbox"/> Yes (Obtain Copy for Chart) <input type="checkbox"/> No (Offer Packet – Contact Quality) <input type="checkbox"/> 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:			