BLUE VALLEY BEHAVIORAL HEALTH- Registration Form

Admission Date: ________________ Location: __________

CLIENT DEMOGRAPHIC INFORMATION

Last Name:__________________________ First: _____________________________ MI:__ Suffix: ____

Previous Last/Maiden Name: ___________________________________

Mailing Address: ___________________________ City: _________________ State:______ Zip: ______

County of Residence: _______________________ County of Admission: ______________________

Phone Contact:
Home #:
Cell #:

Preferred Contact Manner:
○ Home Leave Message Y / N
○ Cell Leave Message/Text Y / N

Date of Birth: ___________ **Age:** _____ **Gender:** _______ **Social Security Number:** ____________

Are you referred by a medical provider/care setting? Y / N
Race: ○ Alaska Native ○ American Indian ○ Asian ○ Black or African American ○ Native Hawaiian ○ Other Pacific Islander ○ White
Ethnicity: ○ Cuban ○ Hispanic (specific origin unknown) ○ Mexican ○ Not of Hispanic Origin ○ Other Specific Hispanic ○ Puerto Rican ○ Unknown
Preferred Language: **US Citizen** Y / N **Immigration Number:**
VOTER REGISTRATION: Are you currently registered to vote? Y / N Would you like to receive an application today? Y / N
Is youth/family involved with Juvenile Court? Y / N Is youth receiving services voluntarily w/o court involvement? Y / N

FINANCIAL INFORMATION:

Primary Income Source: (If client is a minor, answer according to family primary income) ○Disability ○Employment ○Public Assistance ○Retirement/Pension ○None ○Other
Additional Source of Income: (If client is a minor, answer according to family additional source of income) ○Disability ○Employment ○Public Assistance ○Retirement/Pension ○None ○Other
SSI/SSDI Eligibility: ○Determined to be ineligible - N/A ○ Potentially Eligible ○Eligible – Receiving Benefits ○Eligible – Not Receiving Benefits
Medicare/Medicaid Eligibility: ○Determined to be ineligible - N/A ○ Potentially Eligible ○Eligible – Receiving Benefits ○Eligible – Not Receiving Benefits
Health Insurance Coverage: ○Child Welfare ○Indian Health Services ○Medicare ○Other Direct Federal ○Other Insurance ○Private – Self Paid ○HMO ○Medicaid ○No Insurance ○Other Direct State ○PPO ○Veterans Administration
Primary Source of Payment: ○Blue Cross/Blue Shield ○No Charge ○Self Pay ○State Medicaid ○Workers Compensation ○EAP ○Other Source ○State Behav Health Funds ○State Medicare ○HMO/PPO ○Private Health Ins ○State Children and Fam Svc ○Unknown

Client's Employer: ____ Phone: ____________________

Emergency Contact: Name _________________ Relationship to Client __________ Phone ___________

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Marital Status: ○Cohabitating ○Divorced ○Married ○Never Married ○Separated ○Widowed	
Veteran: Y / N	
Are services being pursued due to concerns with someone close to you (i.e. spouse or significant other?) Y / N	
Disability: ○Blindness/Severe Vision Impairment ○No Observable Handicap or Impairment ○Deafness/Severe Hearing Loss ○Nonuse/amputation of limb ○Development Disability/Mental Retardation ○Non-ambulation/severe difficulties	

Does client have a primary health care provider (PCP)? Y / N

Primary Care Physician:______________________ PCP Phone:____________ PCP Fax:____________

Have you had a physical within the last 12 months? Y / N Year and Month last seen? ______________

Height:_________________ Weight: _______________

In the last 30 days, how many days did you experience physical health concerns? (i.e. illness, injury, pain) ______

In the last 30 days, how many days did you experience mental health concerns? (i.e. anxiety, depression) ______

Do you use tobacco? Y / N

During the last 12 months, have you tried to quit smoking? Y / N

Are you aware of the Nebraska Quit line? Y / N Have you attempted to use this quit line? Y / N

Current Medications (List): ______________________________ ______________________________
__________________ ______________________________ ______________________________
__________________ ______________________________ ______________________________

Adverse reactions/allergies to medication? Y / N If yes, describe ______________________________
____

How many opioid pain medications are you taking (i.e. Vicodin, OxyContin, etc.)? If unsure list 0: ____________

How many non-opioid pain medications are you taking (i.e. Tylenol, Advil, etc.)? If unsure list 0: ____________

Do you attend any self-help/social support groups? Y / N If yes, number of times per month ______________

Are you *currently* experiencing any of the following medical conditions/symptoms?

Abnormal Bleeding/Bruising	**Y N**	Food Allergies	**Y N**	MRSA	**Y N**	STD/HIV/AIDS	**Y N**
Asthma	**Y N**	Head Injury/Concussion	**Y N**	Parkinson's Disease	**Y N**	Thyroid Disease	**Y N**
Autoimmune Disease	**Y N**	Heart Disease	**Y N**	Pregnant	**Y N**	Tuberculosis	**Y N**
Blood Clots	**Y N**	Hepatitis (specify type___)	**Y N**	Renal Disease	**Y N**	Ulcers	**Y N**
Cancer	**Y N**	High Blood Pressure	**Y N**	Seizure	**Y N**	Whooping Cough	**Y N**
COPD	**Y N**	Influenza	**Y N**	Shortness of Breath	**Y N**		
Diabetes	**Y N**	Liver Disease	**Y N**	Special Diet	**Y N**		
Eating Disorder	**Y N**	Migraines	**Y N**	Other **Y N** Explain:			

Do you have a Legal Guardian? Y / N If yes, name ____

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Number of Dependents: **(including self and spouse)**	**Annual Family Gross Income** ***(to nearest $1000)*:**

FINANCIALLY RESPONSIBLE PARTY: (Guarantor/Guardian Information):
Parent/Guardian complete this section *if patient is a minor*

Name: ____ Phone: ______________

Address: _________________________ City: ___________________ State: _____ Zip: _______

Social Security #: ________________ Date of Birth: ____________ Relationship to Client: __________

Employer: ______________________________________ Phone: ________________________

PRIMARY INSURANCE INFORMATION:

Name of Insurance: _____________________________________ Copy of card on file: ○ Yes ○ No

ID #: ___________________________ Group #: __________________ Eligibility Date: __________

If Cardholder is different than Responsible Party: Last Name: _________________ First: __________

Relationship to Client: ____________________ Address: _________________________________

City: ___________________________ State: __________ Zip: _______ Phone #: ____________

Social Security #: ______________ Employer: ______________________ Date of Birth: __________

SECONDARY INSURANCE INFORMATION:

Name of Insurance: _____________________________________ Copy of card on file: ○ Yes ○ No

ID #: ___________________________ Group #: __________________ Eligibility Date __________

If Cardholder is different than Responsible Party: Last Name: _________________ First: __________

Relationship to Client: ____________________ Address: _________________________________

City: ___________________________ State: __________ Zip: _______ Phone #: ____________

Social Security #: ______________ Employer: ______________________ Date of Birth: __________

YOUTH ONLY

Days of School Missed (last 3 months): ○ 1 day every 2 wks ○ 1 day per wk ○ 1 or less days per mo.
○ 2 or more days per wk ○ Home Schooled ○ Not Enrolled

Involved with Juvenile Services: ○ Drug Court ○ Not Involved w/Juvenile Serv. ○ OJS State Ward
○ Other Court Involvement ○ Probation

Stable Environment (Legal Custody): ○ Emancipated Minor ○ Guardian ○ Parent(s) ○ Ward of the State

Receiving Professional Partner Service? Y / N **Receiving Special Education Services?** Y/ N