BLUE VALLEY BEHAVIORAL HEALTH- Registration Form

CLIENT DEMOGRAPHIC INFORMATION

Last Name:__________________________ **First:** _____________________________ **MI:** _____________

Previous Last/Maiden Name: ________________________ **Preferred Name:** ______________________

Mailing Address: ____________________ **City:** _________________ **State:**___________ **Zip:** _______

County of Residence: _____________________ **County of Admission:** _____________________

Cell #: ___________________ **Leave Message/Text:** ○ Yes ○ No

Home #: ___________________ **Leave Message:** ○ Yes ○ No

Preferred: ○ Cell ○ Home **Reminder Notification:** ○ Phone ○ Text ○ Both

Date of Birth: ___________ **Age:** __________ **Gender: M / F** **Other Gender:** ____________________

Social Security Number: __________________________ **Referral Source**: _________________________

Race: ○ American Indian/Alaskan ○ Asian ○ Black or African American ○ Hawaiian/Pacific Islander ○ White ○ Other

Ethnicity: ○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Preferred Language: ____________________ **US Citizen: Y / N** **Immigration Number:** _____________

Marital Status: ○ Divorced ○ Married ○ Single ○ Separated ○ Widowed ○ Other

Military Service: Y / N **Family have Military Service: Y / N**

Height (in):________________ **Weight (lb):** _____________ **Currently pregnant:** Y / N

SSI/SSDI Eligibility: ○Determined to be ineligible - N/A ○ Potentially Eligible ○Eligible – Receiving Benefits ○Eligible – Not Receiving Benefits

Health Insurance Status:
○Child Welfare ○Indian Health Services ○Medicare ○Other Direct Federal ○Other Insurance ○Private/Self Pay
○HMO ○Medicaid ○No Insurance ○Other Direct State ○PPO ○Veterans Administration

Primary Funding (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 Fam Svc ○Unknown

Number of Dependents: ____________

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

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

Do you attend any self-help/social support groups? ○ No attendance in past month ○ 1-3 times per month ○ 4-7 time in last month ○ 8-15 times in past month ○ 16-30 times in past month ○ Some attendance, frequency unknown

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Current Medications (List): ______________________________ ________________________________

__________________________ ______________________________ ________________________________

_________________________ ______________________________ ________________________________

__________________________ ______________________________ ________________________________

Adverse reactions/allergies to medication (NKA)? Y / N If yes, describe ____________________________

____

Are you currently experiencing any of the following medical conditions?

Abnormal Bleeding/Bruising	**Y N**	Arthritis	**Y N**	Asthma	**Y N**
Autoimmune Disease	**Y N**	Blood Clots	**Y N**	Cancer	**Y N**
Chronic Fatigue	**Y N**	COPD	**Y N**	COVID-19	**Y N**
Dementia	**Y N**	Diabetes	**Y N**	Eating Disorder	**Y N**
Food Allergies	**Y N**	Fibromyalgia	**Y N**	Head Injury/Concussion	**Y N**
Heart Disease	**Y N**	Hepatitis (Type _____)	**Y N**	High Blood Pressure	**Y N**
Influenza	**Y N**	Liver Disease	**Y N**	MRSA	**Y N**
Migraines	**Y N**	Parkinson's Disease	**Y N**	Pregnancy	**Y N**
Renal Disease	**Y N**	Seizures	**Y N**	Shortness of Breath	**Y N**
Special Diet	**Y N**	STD/HIV/AIDS	**Y N**	Thyroid Disease	**Y N**
Tuberculosis	**Y N**	Ulcers	**Y N**	Whooping Cough	**Y N**
Other **Y N** If yes, please explain:				None	**Y**

Primary Care Physician: ______________________ **PCP Phone:** ________________ **PCP Fax:**______________

Client's Employer: ____ **Phone**: _______________________

Emergency Contact Name: ___________________ **Relationship to Client** _________ **Phone** ____________

Do you have a Legal Guardian? **Y / N If yes, name** ____________________________ **Phone** _____________

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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: ______________