##  **New Horizons Mental Health Services**

# **REGISTRATION FORM**

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| Today’s Date:  |

client INFORMATION

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| Last name:  | First:  | Middle Initial: |  |
| Parent/Guardian (if minor): |  |
| Birth date: | Age: | Gender: | Social Security No.: |

Address: City: State: Zip Code:

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| --- | --- | --- |
| County of Residence: | Home phone no.: | Cell phone no.: |
| Employer: | Position: | Employment Start Date: |
| Employment Status: (Please select one) □ Full Time (35+ hrs) □ Part Time (21-35 hrs) □ Sheltered □ Unemployed (Actively looking for work)□ Disabled □ Engaged in Residential/Hospitalization □ Homemaker □ Inmate □ Retired □ Student □ Volunteer Worker  |
| □ Other not in labor force □ Unknown  |
| Military Status: (Please select one) □ Active □ Discharged □ Disabled veteran □ None |
| Number of arrests in the past 30 days:  |
| Marital Status: (Please select one) □ Divorced □ Married and living together □ Separated □ Single-Never Married □ Widowed □ Unknown |
| Living arrangement at admission: □ Private residence-Adult □ Private residence-Child □ Residential care/Group home/ ACF □ Foster care □ Permanent supportive housing □ Community residence □ Temporary housing □ Foster care □ FDD licensed/Operated facility □ Correctional facility □ Homeless □ Other □ Unknown  |
| Current Education Enrollment: (Please select one) □ Pre-school □ K-12th grade □ GED classes □ College □ Vocation/Job training □ Other schooling (e.g., Adult basic Ed., literacy) □ Has not attended school in last 3 months □ Unknown  |
| Highest Education Level Completed □ < 1st grade □ 1st grade □ 2nd grade □ 3rd grade □ 4th grade □ 5th grade □ 6th grade □ 7th grade □ 8th grade □ 9th grade □ 10th grade □ 11th grade □ 12th grade □ High school diploma/GED □ Technical school □ Some college □ 2 year college/Associate degree □ 4 year college/Bach degree □ Graduate degree □ Unknown |
| Education type: □ Has Individual Education Plan (IEP) □ Does not have Individual Education Plan (IEP)  |
| Referred by: □ Individual (self-referral/family/friend) □ AOD care provider □ Mental health provider □ Other health provider □ School □ Employer/EAP □ Child welfare (CDJFS, CSBS) □ Ohio Family and Children First Council □ Court □ Other |
| Race: (Please select one) □ White □ African American/Black □ Asian □ Other | Ethnicity: □ Hispanic /Latino □ Non-Hispanic/Latino  |
| Disabilities:  |
| Client needs the assistance of an interpreter? Client needs assistance with visualization of material format? |
| Behavioral Health Advance Directives? □ Yes □ No, but like to request information □ No, and declines information |
| PRIMARY CARE PHYSICIAN

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| Name of Primary Care Physician: □ Do not have onePhysician Address: Phone number:  |

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INSURANCE INFORMATION(Please give your insurance card to the receptionist)

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| Person responsible for bill: Home Phone: |
| Address (if different):  |

Please indicate primary insurance: □ EAP

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| --- | --- | --- |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: |
| Policy or Medicaid No: | Group No: | Co-payment: |

Patient’s relationship to subscriber: Please indicate secondary insurance (if applicable):

|  |  |  |
| --- | --- | --- |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: |
| Policy or Medicaid No: | Group No: |  |

Patient’s relationship to subscriber: The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to New Horizons Mental Health Agency. I understand that I am financially responsible for any balance. I also authorize New Horizons Mental Health Services or insurance company to release any information required to process my claims.

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|  | Patient/Guardian signature |  | Date |  |

emergency Contacts**In case of an emergency of if we are unable to reach you, New Horizons Staff may contact the following:**□ Client/Guardian declines to provide emergency contact or there is not one available. Staff Initials \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| Name:  | Relationship to Client: |
| Address:  |
| City: State: Zip: Phone no.:  |

 **Is there anyone else we may call (For example: Your employer, family member, friend, pastor, etc)?** □ Yes □ No

|  |  |
| --- | --- |
| Name:  | Relationship to Client: |
| Address:  |
| City: State: Zip: Phone no.:  |

**Is there someone who can call on your behalf (For example: Spouse, partner, adult child, etc)?** □ Yes □ No

|  |  |
| --- | --- |
| Name:  | Relationship to Client: |
| Address:  |
| City: State: Zip: Phone no.:  |

New Horizons will not release any clinical information to these contacts. Discussing clinical information requires a signed release of information. Your clinical information is strictly confidential. |