## **New Horizons Mental Health Services**

# **REGISTRATION FORM**

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| |  | | --- | | Today’s Date: |  client INFORMATION  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | Last name: | | | First: | | Middle Initial: |  | | Parent/Guardian (if minor): | | | | | |  | | Birth date: | Age: | Gender: | | Social Security No.: | |   Address: City: State: Zip Code:   |  |  |  |  | | --- | --- | --- | --- | | 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  |  | | --- | | Name of Primary Care Physician: □ Do not have one  Physician Address: Phone number: | | | | |  INSURANCE INFORMATION(Please give your insurance card to the receptionist)  |  | | --- | | Person responsible for bill: Home Phone: | | Address (if different): |   Please indicate primary insurance: □ EAP   |  |  |  | | --- | --- | --- | | 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.   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  |  |  |  | |  | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  | | --- | --- | | 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. |