Date: _____

Client Registration

Personal Information:

Name _____
Last Middle (Maiden) First
Street Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Work _____ Cell _____
E-mail _____ Gender _____ SS# _____
Date of Birth _____ Marital Status _____ Occupation _____
Employer _____ Spouse/Significant Other _____
Emergency Contact _____ Relationship _____
Emergency Contact Phone Number _____

Responsible Party (if different than client)

Name _____
Last Middle First
Relationship to Client _____
Street Address _____ City _____ State _____ Zip _____
E-mail _____ Employer _____ Occupation _____
Home Phone _____ Work _____ Cell _____

Meaningful Use Data:

Preferred Language: _____

To ensure our clients get the best care possible we would like to gather data on racial and ethnic background.

Do you consider yourself Hispanic/Latino? Yes No Declined

Which category best describes your race?

White. Native American. Asian. African American. Pacific Islander. Native Hawaiian. Decline

Insurance Information

Primary _____
Name of Insured _____
Relationship to Client _____
Insured's Date of Birth _____
SS # _____
Subscriber's Member # _____
Group # _____
Address _____
Insurance Phone _____

Secondary _____
Name of Insured _____
Relationship to Client _____
Insured's Date of Birth _____
SS # _____
Subscriber's Member # _____
Group # _____
Address _____
Insurance Phone _____

In Case of Emergency:

Contact _____ Relationship _____
Phone _____

Referral Information

Reason for Referral _____

Referred to Bridges by (Please check one box)

- o Dr. _____
- o Therapist _____
- o Insurance Plan _____
- o Hospital _____
- o Family _____
- o Friend _____
- o Other _____

Release of Information

Best contact number to reach you: Home _____ Cell _____ Work _____ Other _____

May we leave a voicemail message: Yes _____ No _____

May we contact you by text Message Yes _____ No _____

Do we have your permission to leave a message with anyone who might answer the phone number you have indicated
Yes_____ No _____

I give The Bridges Program permission to discuss my care or release Private Health Information (PHI) to the following:

Name	Relationship	Contact Information

Client or Legal Guardian Signature: _____

Client or Legal Guardian Printed Name: _____

Date: _____