Date: _____

Client Registration

Personal Information:

Name:_____
Last Middle First

Address:_____

City_____ State_____ Zip Code _____

Home Phone _____ Work_____

Cell_____

E-mail _____ Gender _____

Social Security Number_____

Date of Birth: _____
Marital Status: _____
Occupation:_____

Employer:_____
Name of Spouse or Significant Other _____

Responsible Party (if different than client)

Name:_____
Last Middle First

Relationship to Client:_____

Address: _____City:_____
State: _____

Zip Code _____
E-mail _____

Employer _____
Occupation _____

Home Phone _____
Work _____
Cell _____

In Case of Emergency:

Contact _____
Relationship _____

Phone _____

Referral Information

Referral Reason: _____

Referred to Bridges by (Please check one box)

- Dr. _____
- Therapist _____
- Hospital _____
- Family _____
- Friend _____
- 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

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 Decline to Answer

Which category best describes your race?

White Native American Asian African American Pacific Islander Native Hawaiian

Decline to Answer

Client or Legal Guardian Signature:

_____

Date: _____

Client or Legal Guardian Printed Name: _____

Date: _____

Medical Information:

Height: _____
Weight: _____

Any Diagnosed Illness or Mental Health Disorder(s):

_____
_____
_____

Past/Prospective Surgeries and Dates:

_____
_____
_____

Medications:

_____
_____

Allergies: _____

Any Special Needs:

_____

Impairments in Dexterity, Flexibility or Mobility:

_____
_____
_____