

**Please Fax the completed form to 440-974-8816**

**Please DO NOT send medical records to this fax number**

**New Client Registration Form** (Please Print)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Name: | | Birth Date: | | Social Security #: |
| Home Phone:  OK to leave a message: ❏ Y ❏ N | | Mobile Phone:  OK to leave a message: ❏ Y ❏ N | | Gender: ❏ Male ❏ Female |
| Address: | | | | |
| City: | | State: | | Zip Code: |
| Email Address: | | | | Ok to send emails? ❏ Yes ❏ No |
| Parent/Legal Guardian (If Applicable): | | | | Phone Number: |
| Emergency Contact: | | Phone Number: | | Relationship to Client: |
| Reason for Referral | | Referral Source: | | Patient Discharge Date: |
| Signature Health Location to receive services from:  ❏ Ashtabula ❏ Beachwood ❏ Lakewood ❏ Maple Heights ❏ Painesville ❏ Willoughby | | | | |
| Health Insurance Plan(s) ❏Medicare ❏Medicaid ❏Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Billing/MMIS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| US Citizen: ❏ Yes ❏ No | | Active Military : ❏ Yes ❏ No  Veteran: ❏ Yes ❏ No | | Primary Language:  Translator Needed: ❏ Yes ❏ No |
| Race: ❏ American Indian/Alaska Native ❏ Black/African American ❏ White/Caucasian ❏ Hispanic  ❏ Native Hawaiian/Pacific Islander ❏ Multiracial/Multicultural ❏ Asian ❏ Declined/Unknown | | | | |
| Ethnicity: ❏Hispanic ❏Not Hispanic ❏Unknown ❏Declined | | | | |
| Any difficulty ❏ hearing, ❏ reading or ❏ writing? If checked, please explain | | | | |
| Any special communication needs or physical accommodations needed for the appointment? ❏ Yes ❏ No  If yes, please explain | | | | |
| **Gender at Birth**: ❏ Male ❏ Female  **Gender Identity**: ❏ Male ❏ Female ❏ Transgender Female to Male ❏ Transgender Male to Female ❏ Other ❏ Chose not to disclose  **Sexual Orientation:**  ❏ Lesbian/Gay ❏ Straight ❏ Bisexual ❏ Something Else ❏ Don’t Know ❏ Chose not to disclose | | | | |
| Monthly Income Amount: | Source of Income: | | Household Size: | |

**Referring Facility Information**

|  |  |  |
| --- | --- | --- |
| Facility Name: | Contact Name: | Phone Number: |
| Address: | | |
| City: | State: | Zip Code: |