| **Aiken Barnwell CMHC Adult Patient Registration Form** | |
|---|---|
| Date: | Arrival Time: |
| Name of Insurance Provider: | Policy#/Member#: |
| Reason for Seeking Services at ABMHC: | |
| Name (including maiden name): | |
| DOB (Month, Day, Year): | |
| Address: | |
| Phone Number (Home): | Cell: |
| Email Address (if you want to receive email from agency): | |
| Do you wish to receive texts from agency? ☐No ☐Yes If yes, list number: | |
| Social Security Number: | |
| Marital Status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other | |
| Living Situation: ☐Alone ☐w/spouse ☐w/children ☐ w/siblings ☐w/parents ☐Group Home ☐Homeless ☐Shelter ☐Other (Please list) | |
| Total # of persons living in the household/family size: | |
| Gender: ☐ Male ☐Female ☐Other (Specify) | |
| Race/Ethnicity: (Please list your race/ethnicity) | |
| Educational History: (Highest grade completed) | |
| Are you currently employed? ☐No (Date last employed) ☐Yes (Please list your employer & occupation.) | |
| Did you serve in the military? ☐ No ☐Yes (Please list type of service, dates of service and type of discharge? | |
| Name of Primary Care Provider: | |
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