Aiken Barnwell CMHC Child, Adolescent Family Patient Registration Form	
Date:	Arrival Time:
Name of Insurance Provider:	Policy#/Member#:
Reason for Seeking Services at ABMHC:	
Child's Name:	DOB (Month, Day, Year):
Child's Address:	
Phone Number (Home):	Cell:
Child's Social Security Number:	
Parent/Guardian Name:	
Parent/Guardian Address:	
Parent/Guardian Social Security Number:	
Email Address (if you want to receive email from agency):	
Do you wish to receive texts from agency? ☐No ☐Yes	
Marital Status: ☐ Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Other	
Living Situation: ☐Alone ☐w/spouse ☐w/children ☐ w/siblings ☐w/parents ☐Group Home ☐Homeless ☐Shelter ☐Other	
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.)	
Are you currently attending School? ☐No ☐Yes	
What grade are you in?	
Name of School:	
Name of Primary Care Provider:	