Adult Mental Health Admissions Department

PPBH Psychiatric Emergency Services

Demographics Information

Today's Date:	Client Name:	Client #:
Address:	City/State:	Zip:
Mailing same as above? YES NO	If no, mailing address:	
County of residence: _____Out of state _____Unknown		
Home phone:	Cell phone:	Work phone:
Email Address:		

Age:	DOB:	Gender: M F Other:	Social Security #:
Sexual Orientation: ____Straight ____Gay ____Lesbian ____Bisexual ____Prefer not to answer Other: _____			
Marital status: ____Single ____Married ____Separated ____Divorced ____Widowed Other:_____			
Race: ____White ____Black/African Am. ____Native Am. ____Asian ____Hawaiian/ Pacific Islander ____Alaskan ____Unknown			
Ethnicity: ____Puerto Rican ____Mexican ____Cuban ____Other Hispanic ____Not Hispanic or Latino ____Nepali ____Bhutanese Other: _____			

Have you ever served in the military? YES NO		Has a Loved one served in the military? YES NO	
Parent/Guardian IF Minor:		Parent/Guardian Phone:	
Emergency Contact:	Address:	Phone:	Relationship:
Education Level: ____Less than 12th grade ____Some collage ____HS Diploma/GED ____Bachelor Degree ____Vocational/Tech Diploma ____Graduate Degree ____Unknown		Occupation: _____Not employed	
Primary Language:		Will you need an interpreter? NO If yes, Specify:	
Will client need assistance with visualization of material or alternate format? NO YES:			

Advance Directive

____Yes, Advance Medical Directive (If selected, please provide copy to PPBH)
____Yes, Advance Mental Health Directive (If selected, please provide copy to PPBH)
____No, Advance Medical Directive (If no, and you would like information regarding Advance Medical Directives, contact the Summit County Medical Society)
____No, Advance Mental Health Directive (If no, an information brochure is available at reception and more detail can be provided)

Preferred Pharmacy:	Address:	Phone:

PLEASE TURN OVER

Household Income

Gross total monthly income/source of income (including spouse):	Family Size:

Payors/Insurance Coverage

___ Medicaid Medicaid #: ___ Medicare Medicare #:	Medicaid Spend down amount:

___ EAP Involved/Eligible	Company Name:

Primary Private Insurance:	Plan #:	Group #:
Secondary Private Insurance:	Plan #:	Group #:
Insurance Company phone:	___ Workers Comp ___ Veteran/VA ___ Self Pay	Other:

Acknowledgment of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of Portage Path Behavioral Health's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer listed in the notice. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified or changed in any way."

_____ _____ _____

Client or Legal Guardian Signature Client Number Date

Acknowledgment of Calls/Texts related to my care at Portage Path Behavioral Health

I give consent to Portage Path Behavioral Health to contact me by phone regarding my care at Portage Path Behavioral Health to the Preferred Phone Number on file. This consent will be valid through my current treatment at Portage Path Behavioral Health. I understand that I have the right to restrict this consent by completing a HIPAA Request for Restriction form. This form will be available at your admission appointment.

___ Yes ___ No

_____ _____

Client or Legal Guardian Signature Date