Memorial Behavioral Health

APPLICATION FOR SERVICES

FOR OFFICE USE ONLY

*Client ID#:*_____

Date of application: _____

CLIENT INFORMATION

First name: _____ MI: _____ Last name: _____

DOB: ____ / ____ /_____ Age:_____ SS#: _____ U.S. Citizen: ❑ Y ❑ N

Gender Identity: ❑ Male ❑ Female ❑ Transgender ❑ Non-Binary ❑ Other ❑ Prefer Not To Say

Preferred Pronouns: ❑ He/Him/His ❑ She/Her/Hers ❑ They/Them/Their ❑ Prefer Not To Say

Race:

❑ Black or African American	❑ American Indian or Alaskan Native	❑ Asian or Asian American
❑ Hispanic, Latino, Latinx or of Spanish Origin	❑ Middle Eastern or North African	❑ Native Hawaiian or Other Pacific Islander
❑ White	❑ Two or More Races, Ethnicities or Origins	❑ Other Ethnicity or Origin

Maiden or Chosen Name: _____ Mother's maiden name: _____

Contact Information:

Address: _____

City: _____ State: _____ ZIP: _____

Primary Phone: _____ ❑ Cell ❑ Home ❑ Work ❑ Other

Secondary Phone: _____ ❑ Cell ❑ Home ❑ Work ❑ Other

Email address: _____

Preferred language: ❑ English ❑ Arabic ❑ Chinese ❑ French ❑ Spanish ❑ Sign Language ❑ Other _____

Interpreter service needed? ❑ Y ❑ N

Legal Status: ❑ DCFS Ward ❑ Parent (If Under 17) ❑ Self/Own Guardian ❑ Legal Guardianship

Parent/Guardian name: _____

Address *(if different than above)*: _____ Phone: _____

In case of an emergency:

Name: _____ Relation: _____ Phone: _____

Primary Care Physician: _____ Agency: _____ Phone: _____

Hospital preference: _____ City: _____

Medical Information:

Allergies: _____ Medications: _____

Education: ❑ Never Attended or Check Highest Grade Level Completed

❑ Pre-school/Kindergarten	❑ One Year College	❑ Bachelor's
❑ High school diploma	❑ Two Years College	❑ Master's or Post Grad
❑ GED	❑ Three Years College	

Name of school *(if currently a student)*: _____ Grade: _____

Employment: *Check all that apply*

❑ Full-time ❑ Part-time ❑ Disabled ❑ Homemaker ❑ Retired ❑ Student ❑ Unemployed ❑ Other _____

Marital status: ❑ Single/Never Married ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Military status: ❑ Not a veteran ❑ Veteran Active duty: ❑ Y ❑ N

Reason for seeking treatment: _____ **Referred by**: _____

Preferred Appointment Method: ❑ Video ❑ Phone ❑ In Person

Appointment Reminder Preference: ❑ Phone Call ❑ Text Message

If not available, appointment reminder calls may be made to (name): _____

Relation: _____ Phone #: _____

Okay to leave a message? ❑ Y ❑ N

INSURANCE INFORMATION

Do you have Medicaid? ❑ Y ❑ N Recipient #: _____

Do you have Medicare Part B? ❑ Y ❑ N Medicare #: _____

Does any other insurance apply? ☐Y ☐N *If yes, complete next section.*

Insured first name: _____ MI: ___ Last name: _____

Address *(if different than client)*: _____

City: _____ State: _____ ZIP: _____

Employer:_____ Address: _____

SS#: _____ Insurance Company: _____

Plan/policy #: _____ Member ID #: _____