Mental Health Community Centers
Support Starts Here.

Member Registration

General Information

		Date	Time

Member Name:	(Last)	(First)	(Middle)	(Suffix)

Gender: Male ☐ Female ☐	Alias / Maiden Name:

Date of Birth:	SSN:	Citizenship: U.S. ☐ Other ☐
Cell #:	Home#:	Work #:
Ok to call?	Ok to leave a message?	Email:

Address:	City:

State:	Zip Code:	Are you at risk of being homeless? Y or N
Primary Language English ☐ Other ☐:		Are you a Smoker? Y or N
U.S. Military Veteran?	Branch:	Status:
Who referred you to MHCCI?		Phone #:

Contact info:

Parent/Guardian Name:		Relation to Member:
Date of Birth:	SSN:	Guardian Documentation: Y or N
Home #:	Work #:	Employer:
Address:	City:	
State:	Zip Code:	Marital Status:

Emergency Contact Name:	Relationship:
Phone #:	Work #
Address:	City:
State:	Zip Code:

Insurance Information

Medicaid # ______________________________ Medicaid Type: _________________________________

Medicare # ______________________________Medicare Type: A ☐ B ☐ D ☐ HMO ☐ : ___________________

Insurance Company ____________________________ Primary's Employer ____________________________
Primary's Name: _______________________________________ SS# _______________________ DOB _______________
Policy # __________________________ Group # ________________________
Benefits Phone _________________________________ Relationship to Primary ________________________

Are you in counseling? Yes☐ No☐ Provider: ______________________________ Phone ____________________

Primary Care Physician: ________________________________ Last Seen: ________________ Phone _____________

Psychiatrist: ___________________________________ Last Seen: ________________ Phone _____________

Current Medications: ____

Number of Psych hospitalizations in the last year: ____

Allergies:________________ Medical Conditions:_______________________ Limitations:______________________

I am a smoker and have received brief counseling Yes / No / Declined**. I have received a referral to a Tobacco Treatment Specialist** Yes / No / Declined**. I have received additional Tobacco Treatment resources:** Yes / No / Declined Signature: ____ Date:________

By signing below I certify this information to be true to the best of my knowledge.

Member Signature: ____ Date: ___________________________

Staff Signature: __________________________________ Staff ID#: _______________ Date: _____________________