Towns Health Services Inc.

Health Care Services

Towns Health Services 750 Spaans Drive Suite C, D, F Galt CA 95632 Phone:209-744-9909 Fax:209-744-9910

New Patient Registration

Patient Information:	Date: ____________________
Name: Last	First
Address: Street	City State and Zip Code
Phone (Cell):	(Work):
Phone (Home)	Marital Status:
Social Security Number:	Birth Date:
DL or ID #:	State of ID /DL:
Email Address:	
Gender: Male Female Other	Transgender:
Preferred Language:	Religion:

Race:

American Indian or Alaska native   Asian   Black or African American   Other ____________

Native Hawaiian or other   Pacific Islander   White   Unknown/Declined to answer

Pregnant:	No Yes
If Yes, Due Date if known	
Is it OK to leave a message on the phone number provided?	No Yes
Would you like to subscribe to appointment reminders?	No Yes
Are you a U.S. Citizen?	No Yes
Do you currently have Medi-Cal?	No Yes
If yes, what county do you reside in (live)?	
How will you get to the clinic?	
Referred By:	
Why are you seeking Treatment:	

Precipitating Events Leading Patient to Seek Treatment?

A. Inability to maintain employment   B. Threatened Job Loss   C. Financial Problem
D. Deterioration of family relationships   E. Divorce/Separation/Break-up relationship   F. Overdose
G. Threatened divorce or break-up   H. Deterioration of health   I. Other

Please Indicate Other:	
Do you have any barriers/challenges that could get in the way of your treatment or completion of treatment?	No Yes
Do you want your family/significant other involved in your treatment here at THS?	No Yes

If so, please indicate to which extent. **Circle ones that apply:** A. Family Group Sessions B. Family Individual Sessions C. Treatment Planning D. Other	
Are you a Veteran? Yes No If yes, type of Discharge:	
Are you or have a member in the armed forces?	No Yes
Employer or School:	
Phone #	
Address: Street City State and Zip Code	
Full Time (35 or more hour/week) Part Time (5-34 hours/week)	Length of employment:
A. Satisfied B. Dissatisfied C. Supervisor Conflict D. Co-worker conflict E. At risk of being terminate	
Has anyone at work expressed concern about your substance use?	No Yes
Does your employer require notification of your treatment?	No Yes
Please Indicate types of income/support received: A. None Public Assistance B. SSI/SSD Social Security C. Private Insurance D. Food Stamps/Cal Fresh E. Unemployment F. Veteran Assistance G. Retirement Pension H. Medicaid I. Alimony Child Support J. Family K. Friend L. Other	
How many people are in your household?	
If unemployed, do you think you are eligible for unemployment assistance? N/A	No Yes
Do you need assistance with applying for benefits such as WIC, Food Stamps/Cal Fresh, VA, Medicaid (Medi-Cal), food vouchers, bus pass or any other public benefits?	No Yes

Additional Questions:

Do you have children? Yes No	Do you custody of your Children? Yes No	Number of children in household

Are you currently receiving MAT Services? Yes No	No Yes
Do you have any previous mental health or substance use treatment history?	No Yes

Populate field(s) below with this list of treatments:

A. None	B. Education Programming	C. Medication Assisted Treatment	D. Outpatient
E. Intensive Outpatient	F. Residential	G. Detox/Withdrawal Management	H. Harm Reduction
I. Mental Health	J. Other	K. Transitional Housing/Sober Living	

Substance	Recently Used? Yes /no	Prior Use? (lifetime)	Route (oral, smoke, inject, snort)	Frequency (Daily Weekly, Monthly)	Duration (length of use)	Date & Amount Used	Total Used in last 24 hours	Patterns of Use
Alcohol								
Amphetamine								
Barbiturates								
Cocaine/Crack								
Ecstasy								
Hallucinogen								
Heroin								
Inhalants								
Marijuana/Cannabis								
Methamphetamine								
Nicotine								
Non-Prescription Methadone								
Opioid Pain Medication (Misuse without RX)								
Over The Counter								
OxyContin								
PCP								
Sedatives (Benzos, Sleeping Pills)								
Tranquilizers (Benzodiazepine)								
Other (Specify)								

Insurance Information:

Insurance Company:	
Group No.:	
Member ID:	
Phone #:	
Address: Street	City State and Zip Code
Person Responsible for Bill:	Spouse's or Parent's Employer:
Secondary Insurance:	

NOTICE

IF YOU ARE PLANNING TO USE YOUR INSURANCE TO PAY FOR TREATMENT

You must complete the admission process that includes the medical evaluation procedure, in order to access your medical insurance benefits. Your insurance claim may be denied if you have not completed the lab tests as outlined in the admission procedure material.

Please be advised that some Insurance companies will not pay the full treatment benefit if you drop out of treatment prematurely. If you do drop out early, you will be held responsible for any portion of the bill that your Insurance Company denies.

Also you must remain up to date on your payments for treatment in order to successfully complete the program. So if you have entered this program to satisfy an employer for legal reasons, please stay up to date with your payment plan in order to obtain a satisfactory discharge status.

Please not you will not receive you proof of completion and or certificate until all payments have been complete.

I hereby authorize Towns Health Services Inc. to furnish the above insurance company (ies) with information pertaining to my present illness/injury and or treatment. I hereby assign to Towns Health Services Inc. all money to which I am entitled for addiction treatment expenses relative to the service received. I understand that I and not my insurance are responsible for my bill. In addition I may be eligible for payment plan arrangements. I also understand that a finance charge may be assessed for accounts over **60-90** days past due.

Client Printed Name:___________________________________

Client Signature: ____ Date: ____