Fairmount
Behavioral Health System

REGISTRATION INFORMATION

Patient Identification

TODAY'S DATE: _____

Thank you for choosing Fairmount Behavioral Health System. Our counselors will meet with you for a free assessment and discuss your needs and available alternatives.
In order to assist and your family in identifying available resource, please complete the following information.

PATIENT

NAME (First, Middle, Last)			SOCIAL SECURITY NUMBER	
ADDRESS				
CITY	STATE	COUNTY		ZIP CODE
MARITAL STATUS	DATE OF BIRTH	AGE	SEX	GUARDIAN/SPONSE
HOME TELEPHONE # ( ) -	MAY WE CALL YOU AT HOME? ☐ YES ☐NO	WORK TELEPHONE # ( ) -		MAY WE CALL YOU AT WORK? ☐YES ☐NO
EMERGENCY CONTACT				
RELATIONSHIP	HOME ( ) -	WORK PHONE ( ) -		

DATA

INSURED NAME	INSURED SOCIAL SECURITY NUMBER	DATE OF BIRTH
INSURANCE COMPANY	INSURANCE TELEPHONE NUMBER	IS INSURED PATIENT? ☐YES ☐NO
EMPLOYER		☐ Salary ☐ Hourly
EMPLOYER ADDRESS		☐ Employee ☐ Dependant
CITY	STATE	ZIP CODE
TITLE/ DEPARTMENT	EMPLOYEE I.D. NUMBER	TELEPHONE NUMBER / LENGTH OF EMPLOYMENT _____Years _____Months

HOW DID YOU KNOW TO CALL FAIRMOUNT BEHAVIORAL HEALTH SYSTEM?

CONSENT

This consent is subject to revocation at any time except to the extent that action has been taken thereon. This consent will expire after the action is completed.

I, _____ give the Needs Assessment Staff at Fairmount Behavioral Health System permission to perform an assessment. _____

PATIENT NAME

SIGNATURE

I, _____ give Fairmount Behavioral Health System Permission to verify Insurance benefits to assist with referral services. _____

PATIENT NAME

SIGNATURE

Fairmount
Behavioral Health System

COMMUNICABLE DISEASE QUESTIONNAIRE

PATIENT IDENTIFICATION

Name: _____ **Date:** _____

This brief questionnaire is a screening tool to help identify possible communicable disease.

1. Do you currently have or have you ever had:

Measles	☐ No ☐ Yes
Mumps	☐ No ☐ Yes
Rubella	☐ No ☐ Yes
Chicken Pox	☐ No ☐ Yes
Hepatitis	☐ No ☐ Yes
HIV	☐ No ☐ Yes
Tuberculosis	☐ No ☐ Yes
Other	☐ No ☐ Yes

2. If the answer to any of the above is yes, please list dates: _____

3. Are you now under the care of a physician or taking any medication for a communicable Disease? ☐ No ☐ Yes
   If yes, please explain: _____

4. Have you had recent contact with someone with any of the above illnesses? ☐ No ☐ Yes
   If yes, which one(s): _____

5. Have you ever been tested for Tuberculosis? ☐ No ☐ Yes If yes, when? (Date): _____

6. Have you ever tested positive for TB? ☐ No ☐ Yes
   If you, did you have a chest x-ray? ☐ No ☐ Yes
   Were you treated? ☐ No ☐ Yes If yes, when? (Date): _____
   What kind of treatment? _____

7. Please check yes or no to ALL symptoms as they apply to you:

Productive Cough (3 weeks or more)	☐ No ☐ Yes
Persistent Weight Loss without Dieting	☐ No ☐ Yes
Persistent Low Grade Fever	☐ No ☐ Yes
Night Sweats	☐ No ☐ Yes
Loss of Appetite	☐ No ☐ Yes
Swollen Glands, usually in the Neck	☐ No ☐ Yes
Recurrent Kidney Infections	☐ No ☐ Yes
Shortness of Breath	☐ No ☐ Yes
Chest Pain	☐ No ☐ Yes

FOR STAFF USE ONLY

After review of answers, what actions taken: _____

_____

_____

_____

Reviewed By: _____ Date/Time: _____