Public Health
Prevent. Promote. Protect.
Harford County Health Department

DIVISION OF BEHAVIORAL HEALTH
REGISTRATION FORM

Today's Date:

CLIENT INFORMATION **MEDHELP# ____________**

Client's Last Name : First: Middle Initial:

Legal name: Former/Maiden name(s):

Social Security Number: __ __ __ - __ __ - __ __ __ __

Birth Date: __ _ / __ __ / __ __ __ __ Is the client a United States Citizen Yes / No

Gender (Please Check):
☐ Male ☐ Female ☐ Declined

Please check:
☐ Married ☐ Never Married ☐ Divorced ☐ Separated

Referred By/How did client here about us:

Does client have a Legal Representative? YES / NO

If yes, complete below: Name of Representative:_______________________________

Relationship: __________________Contact Number: ______________________

Address: ____

Documented Verification of Legal Representation Received Y / N

If document was not received, explain: ______________________

Primary Address: ____

Preferred Mailing Address: ____

Home phone # __ __ __-__ __ __-__ __ __ __ Cell phone#: __ __ __-__ __ __ -__ __ __ __ Text: Y / N

Email Address:

Emergency Contact Information:

Name: _____________________________________ Relationship: ________________________

Contact Number: _________________________ Address: ____________________________

Name: ______________________________________ Relationship: ________________________

Contact Number: _________________________ Address: ____________________________

DIVISION OF BEHAVIORAL HEALTH
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Services Requested: Check all that Apply ○ Mental Health ○ Addictions ○ Both ○ Other (Please Specify): Has client received services here before? Yes / No	Referred By: ○ Friend/Family ○ Hospital: Name: ____________________ ○ Other: Please Specify________________

Is client currently enrolled in another drug, alcohol or mental health program, is so please indicate

Name of Program:

Type of Service:

What language does client feel most comfortable speaking in with their counselor?

Reasonable accommodations needed (interpreter, etc.)?

Addictions Only: Please inform client that: Clients who are IV Drug Users have HIV or AIDS or are pregnant may receive priority services. Do they meet this criterion? Yes/ No

If yes, please explain:

INSURANCE INFORMATION **UNINSURED: YES / NO**

Has the client or their immediate family member ever served in Military? Yes or No

Does the client have health benefits through Veterans Administration (VA)? Yes or No

Referred: Yes or No Referral Number: 800-827-1000

Please indicate primary insurance carrier:		Subscriber's name:
Subscriber's S.S. number: __ __ __ - __ __ - __ __ __ __	Subscriber's Birth date: __ __ / __ __ / __ __ __ __	MA/Policy Number:
Client's relationship to subscriber:		

Name of secondary insurance carrier (if applicable):		Subscriber's name:
Subscriber's S.S. number: __ __ __ - __ __ - __ __ __ __	Subscriber's Birth date: __ __ / __ __ / __ __ __ __	MA/Policy Number:
Client's relationship to subscriber:		

Appointment

Appointment Type: **MH Screening** **Orientation** **SUD Intake**

Appointment Scheduled With (Staff Name): **Time:**

Days till first appointment: