Today's Date: ______________________________ *Time: _____*

HAMPTON BEHAVIORAL HEALTH CENTER
REGISTRATION INFORMATION AND HEALTH QUESTIONNAIRE

Welcome to Hampton Behavioral Health Center. One of our Access Center Coordinators will meet with you to discuss your needs and options available. Your assessment is confidential and provided at no charge. We will make every attempt to answer your questions and concerns. Please return, to the receptionist, when you have finished.

THE NOTICE OF PRIVACY PRACTICES: *Hampton Behavioral Health Center maintains a policy to ensure patients' and/or employees' rights to privacy. Information about your health is private, and it should remain private. That is why Hampton Behavioral Health Center is required by federal and state law to protect the privacy of your health information. We call it "Protected Health Information" (PHI). It is important for you to understand that it is also your responsibility to respect the right of confidentiality and protected health information. Under no circumstances are patients or treatments to be discussed in public areas of this hospital or outside this hospital. It is also important to understand that you may not acknowledge the presence of any patient in this facility. Information will only be disclosed by this facility with your written permission except as noted below. As a patient at Hampton Behavioral Health Center we take every measure to ensure the safety of your confidential information. Our Notice of Privacy Practices explains how your Protected Health Information (PHI) may be used or disclosed by this hospital. The hospital is required to advise you of its Privacy Practices once in your adult lifetime and whenever the Notice of Privacy Practices is revised. Your Protected Health Information includes: Name, Address, Birth Date, Phone Number, Fax Number, E-mail Address, Social Security Number, Medical Record Number, Health Plan Beneficiary Numbers, Account Numbers, Diagnosis, Procedure.*

You, as the patient, have the following rights:

- *To review the Notice of Privacy Practices; To obtain the revised version of the Notice of Privacy Practices; To restrict the use and disclosure of your Protected Health Information; To revoke any authorization to use or disclose your Protected Health Information in writing at any time.*

The hospital also has rights regarding Protected Health Information:

- *To revise its privacy practices; to disagree with the restriction you make on the use or disclosure of PHI; to be bound by the agreed-to restriction.*

Unauthorized use or disclosure of Protected Health Information is permitted for:

- *Law Enforcement, Research and Public Health purposes, court order and other legal processes, Workers' Compensation, Specialized Government functions, Coroners, Medical Examiners and Funeral Directors.*

PATIENT INFORMATION			
PATIENT NAME		*SOCIAL SECURITY NUMBER*	
ADDRESS			
CITY	*STATE*	*COUNTY*	*ZIP*
PATIENT HOME PHONE	*MAY WE CALL YOU AT HOME?* o Yes o No	*PATIENT WORK PHONE*	*MAY WE CALL YOU AT WORK?* o Yes o No
MARITAL STATUS o Single o Married o Divorced o Separated o Widowed	*DATE OF BIRTH*	*AGE*	*SEX* o Male o Female
EMERGENCY CONTACT	*RELATIONSHIP*	*PHONE NUMBER(S)*	
MEDICATIONS		*ALLERGIES*	

MINOR/LEGAL GUARDIAN INFORMATION				
LEGAL GUARDIAN NAME			*ADDRESS (IF DIFFERENT FROM ABOVE)*	
CITY	*STATE*	*ZIP*	*HOME PHONE NUMBER*	*WORK/ALTERNATE PHONE NUMBER*

PRIMARY INSURANCE INFORMATION			
NAME OF POLICY HOLDER	*RELATIONSHIP TO PATIENT*	*INSURED'S SOCIAL SECURITY*	*DATE OF BIRTH*
INSURANCE COMPANY		*INSURANCE PHONE NUMBER*	
INSURED'S EMPLOYER		*EMPLOYER'S ADDRESS*	

SECONDARY INSURANCE INFORMATION			
NAME OF POLICY HOLDER	*RELATIONSHIP TO PATEINT*	*INSURED'S SOCIAL SECURITY*	*DATE OF BIRTH*
INSURANCE COMPANY		*INSURANCE PHONE NUMBER*	
INSURED'S EMPLOYER		*EMPLOYER'S ADDRESS*	

REFERRAL INFORMATION
Who referred you to our facility today? Please be as specific as possible(i.e.: insurance carrier/managed care organization, primary care physician, psychiatrist, therapist):
What prompted you to come to our facility today?

HEALTH SELF-SURVEY

PLEASE COMPLETE THE BELOW INFORMATION TO THE BEST OF YOUR ABILITY. MEDICAL CLEARANCE MAY BE REQUIRED AFTER REVIEW OF THIS FORM.

Patient Name: ____

HEALTH SELF-SURVEY				
Height:			Weight:	
Do you have any history or been diagnosed with any of these illnesses:	o Asthma o Epilepsy o Heart Disease o Glaucoma o Diabetes	o Bronchitis o Arthritis o Emphysema o Tuberculosis o Hepatitis	o Kidney Disease o Hypertension o Cirrhosis o Cancer o HIV	o Ulcers o Thyroid o Sexually Transmitted Diseases o Other:

SYSTEM REVIEW ***Please check off any problem areas you may have.***				
Neurological	o Headaches o Unsteady walking	o Hearing o Seizures	o Dizziness o Speech	o Vision o Tremor/shaking
Cardiovascular/ Respiratory	o Chest pain o Shortness of breath o Difficulty breathing	o Persistent coughing o Palpitations o Sweating at night	o "Skipped" heartbeat o Short of breath with exercise	o Changes in color or coldness/numbness of extremities
Gastrointestinal	o Problems with eating o Problem digesting	o Heartburn o Nausea	o Frequent diarrhea	o Frequent constipation
Dermatological	o Skin rashes	o Open areas	o Lesions	
Musculoskeletal	o Pain or stiffness when walking	o Arthritis		o Muscle weakness
Other	Are you currently pregnant?	o Yes o No		

		Yes	***No***	***Describe***
Nutritional	Have you had any recent weight gain/loss?			If yes, how much: How long: Days ______ Weeks ______ Months ______
	Have you had any recent changes in eating habits?			
	Do you have any dietary restrictions?			
	Do you have any other problems that might interfere with your nutrition?			
	Do you have any allergies?			
Pain	Do you have any pain now?			
	Have you had pain in the past two months?			
	If yes, are you currently under the care of a physician for this pain?			
	If you are in pain and not under a physician's care, do you require our assistance finding appropriate medical treatment?			

This consent is subject to revocation at any time except to the extent that action has already been taken and will expire after the action is completed. My signature below is allowing the Access Center Staff at Hampton Behavioral Health Center to perform a Level of Care Assessment; I have reviewed the facility's Privacy Practices; to verify insurance benefits and to assist with referral services if recommended.

X____ ____________________

Patient Signature (14 and older) *Date*

____ ____________________

Parent/Legal Guardian/Power of Attorney Signature *Date*