DAYMARK Recovery Services

Patient Information Sheet

Medical Record #: _____
MCO Record #: _____
Client's Medicaid #: _____
Data Entry by: _____

Date Completed: _____

First Name:	Middle:	Last Name:
Preferred Name:	Previous First Name:	Previous Last Name:
Street address:		County of Residence:
City:	State:	Zip code:
Mailing address: ☐ Do not mail		
City:	State:	Zip code:
Date of Birth:	Social Security:	Birth Sex: ☐ Female ☐ Male

Current Gender:	Gender Identity:	Sexual Orientation:	Preferred Pronoun:
☐ Female	☐ Female	☐ Straight/Heterosexual	☐ She/her/hers
☐ Male	☐ Male	☐ Lesbian, gay, or homosexual	☐ He/him/his
☐ Undifferentiated	☐ Female-to-male/Transgender Male	☐ Bisexual	☐ They/them/theirs
	☐ Male-to-female/Transgender Female	☐ Other	☐ Ze/hir
	☐ Genderqueer	☐ Choose not to disclose	☐ Other
	☐ Other	☐ Don't know	☐ Decline to answer
	☐ Choose not to disclose		☐ Asked but unknown

METHODS OF CONTACT

Home phone: ☐ n/a	Cell Phone: ☐ n/a	Day/Work Phone: ☐ n/a	Alternate Phone: ☐ n/a	Secondary Phone: ☐ n/a
Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N	Leave message? ☐ Y ☐ N

Email address: ☐ n/a

Preferred Contact Order: (Write 1, 2, 3, 4, or 5 next to each item to indicate which number to call first, second, third, etc)

_____ Home _____ Cell _____ Day/Work _____ Alternate _____ Secondary

EMERGENCY CONTACT INFORMATION	LEGALLY RESPONSIBLE PERSON
Name:_____	☐ Self ☐ Parent ☐ Legal Guardian ☐ Other: _____
Relationship:_____	Name:_____
Address:_____	Address: _____
City/State:_____ Zip Code:_____	City/State:_____ Zip Code: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____

Primary Care Practice: _____ **Preferred Hospital**: _____

Date of last visit with your Primary Care Practice: _____ ☐ Don't have a Primary Care Practice

Preferred Pharmacy Name: _____ **Pharmacy Address/Phone:** _____

Client name_____ **DOB**_____ **MR#**_____ **Medicaid #** _____

ETHNICITY (check one) ☐ Hispanic-Mexican American ☐ Hispanic-Puerto Rican ☐ Hispanic-Cuban ☐ Hispanic-Other ☐ Not Hispanic	**RACE** (check one) ☐ Black/African American ☐ White/Anglo/Caucasian ☐ Amer Indian/Native American ☐ Alaska Native ☐ Asian ☐ Pacific Islander ☐ Multiracial ☐ Other : _____	**MARITAL STATUS** (check one) ☐ Annulled ☐ Single (never married) ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partners	**Primary Language** (check one) ☐ English ☐ Sign Language ☐ French ☐ Spanish ☐ Other **English Proficiency** (Do you need an interpreter?) ☐ Yes ☐ No
Employment Status (check one) ☐ Unemployed ☐ Employed Full time ☐ Employed Part Time ☐ Student ☐ Retired ☐ Homemaker ☐ Not available for work ☐ Armed Forces ☐ Seasonal/Migrant worker Employer: _____ Occupation:_____	**Self-Help Programs** (check one) How often have you attended a self-help program in the past 30 days? ☐ None in past month ☐ 1-3 times ☐ 4-7 times ☐ 8-15 times ☐ 16-30 times ☐ Some attendance, don't know number	**Living Arrangement** (check one) ☐ Private Residence ☐ Other independent housing ☐ Homeless shelter ☐ Correctional facility ☐ Institution ☐ Residential Facility (excluding nursing homes) ☐ Foster family/alternative family living ☐ Nursing home ☐ Adult care home 7+ beds ☐ Adult care home 1-6 beds ☐ Community ICF-MR ☐ Comm. ICF-MR,70+ beds ☐ Other: _____	**Referral Source** (check one) ☐ Self/no referral ☐ Family/friends ☐ Other outpatient/ residential facility ☐ State facility ☐ Psychiatric service/ general hospital ☐ Non-residential treatment/ habilitation program ☐ Private Physician ☐ Nursing home ☐ Veteran's Administration ☐ Other health care ☐ Community Agency ☐ Court/corrections/prisons ☐ School ☐ Other:_____
Education: Highest Grade Completed or GED or Degree: _____	**Number of Arrests in past 30 days** (include arrest for any cause regardless of current status): _____		
Family Size (number of people living in household, for whom you are financially responsible, including yourself): _____	**Annual Family Income** $_____.00	**Are you a veteran?** ☐ Yes ☐ No	**Females Only:** **Currently Pregnant?** ☐ Yes ☐ No

Insurance Coverage

Medicaid	Yes ☐	No ☐	ID Number:
Medicare	Yes ☐	No ☐	ID Number:
Blue Cross Blue Shield	Yes ☐	No ☐	ID Number:
United Healthcare	Yes ☐	No ☐	ID Number:
Humana	Yes ☐	No ☐	ID Number:
Cigna	Yes ☐	No ☐	ID Number:
Aetna	Yes ☐	No ☐	ID Number:
Other:	Yes ☐	No ☐	ID Number:

To the best of my knowledge, the questions on this form have been answered accurately. I understand it is my responsibility to inform DAYMARK, in writing, when I desire changes in this information, including the method of contacting me.

Completed by: _____ **Date:** _____
(If not client, list relationship)