

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? <input type="radio"/> Yes <input type="radio"/> No		PATIENT WORK PHONE	
				MAY WE CALL YOU AT WORK? <input type="radio"/> Yes <input type="radio"/> No	
MARITAL STATUS <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Divorced <input type="radio"/> Separated <input type="radio"/> Widowed			DATE OF BIRTH	AGE	SEX <input type="radio"/> Male <input type="radio"/> 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 PATIENT	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:	<input type="checkbox"/> Asthma <input type="checkbox"/> Epilepsy <input type="checkbox"/> Heart Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Diabetes	<input type="checkbox"/> Bronchitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Cancer <input type="checkbox"/> HIV	<input type="checkbox"/> Ulcers <input type="checkbox"/> Thyroid <input type="checkbox"/> Sexually Transmitted Diseases <input type="checkbox"/> Other: _____
SYSTEM REVIEW				
<i>Please check off any problem areas you may have.</i>				
Neurological	<input type="checkbox"/> Headaches <input type="checkbox"/> Unsteady walking	<input type="checkbox"/> Hearing <input type="checkbox"/> Seizures	<input type="checkbox"/> Dizziness <input type="checkbox"/> Speech	<input type="checkbox"/> Vision <input type="checkbox"/> Tremor/shaking
Cardiovascular/ Respiratory	<input type="checkbox"/> Chest pain <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Persistent coughing <input type="checkbox"/> Palpitations <input type="checkbox"/> Sweating at night	<input type="checkbox"/> "Skipped" heartbeat <input type="checkbox"/> Short of breath with exercise	<input type="checkbox"/> Changes in color or coldness/numbness of extremities
Gastrointestinal	<input type="checkbox"/> Problems with eating <input type="checkbox"/> Problem digesting	<input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea	<input type="checkbox"/> Frequent diarrhea	<input type="checkbox"/> Frequent constipation
Dermatological	<input type="checkbox"/> Skin rashes <input type="checkbox"/> Open areas <input type="checkbox"/> Lesions			
Musculoskeletal	<input type="checkbox"/> Pain or stiffness when walking <input type="checkbox"/> Arthritis <input type="checkbox"/> Muscle weakness			
Other	Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Nutritional		Yes	No	Describe
	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?			
<p><i>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.</i></p> <p>X _____ Date _____ Patient Signature (14 and older)</p> <p>_____ Date _____ Parent/Legal Guardian/Power of Attorney Signature</p>				