LIFESTREAM BEHAVIORAL CENTER

CONSUMER INFORMATION UPDATE

DO NOT WRITE IN SHADED AREAS – FOR OFFICE USE ONLY

Consumer Type: ☐**ESTABLISHED** ☐**NEW** ☐**NON-ADMIT**	**Date:**	**Preferred Language**:

NAME: Last, First Middle

ALIAS:

DATE OF BIRTH	SOCIAL SECURITY #	**Client ID #**

SEX	RACE	ETHNICITY	MARITAL STATUS
☐M ☐F	☐ American Indian/Alaskan ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ Multi-Racial/Other ☐ Unk ☐ White	☐ Cuban ☐ Haitian ☐ Mexican ☐ Mexican American ☐ None of the Above ☐ Other Hispanic ☐ Puerto Rican ☐Spanish/Latino	☐ Divorced ☐ Legally Separated ☐ Married ☐ Registered Domestic Partner ☐ Separated ☐ Single ☐ Unreported ☐ Widowed

EMPLOYMENT STATUS			
☐Active military, overseas ☐ Active military, USA ☐ Disabled ☐ Employed in family run business	☐ Full time ☐ Full time student ☐ Homemaker ☐ Inmate, criminal	☐ Inmate, other ☐ Leave of absence ☐ Not authorized to work ☐ Part time	☐ Part time student ☐ Retired ☐ Self employed ☐ Terminated/unemployed ☐ Unknown

ADMISSION TYPE	**AGENCY ADMISSION DATE**	**ASSIGNED CLIENT ID#**
☐**Voluntary competent** ☐**Voluntary incompetent** ☐**Involuntary competent** ☐**Involuntary incompetent**		

HOMELESS	CURRENT ADDRESS ZIP CODE CITY STATE COUNTY
☐Yes ☐No	

HOME TELEPHONE #	WORK TELEPHONE #	CELL TELEPHONE #	EMAIL ADDRESS*

PERMANENT ADDRESS ☐Same as Current ☐None ☐ Other as noted below

Permanent Address City State Zip Code

MAILING ADDRESS ☐Same as Current ☐None ☐ Other as noted below

Mailing Address City State Zip Code

PRIMARY CARE PROVIDER (Who do you go to when you have a cold or the flu?)

Name: Address: Phone:

DISCLOSURES OF INFORMATION	**CONSENTS SIGNED:**	REFERRED BY: (provide name, agency, &/or circumstance of referral)
☐ **Family Members, inc Emergency Contact** ☐ **PCP Notification** ☐ **Referral Source (s)** ☐**Other _____**	☐**Agreement for Treatment** ☐**Consumer Guarantor** ☐***Electronic Correspondence** ☐ **Rights & Responsibilities**	

INCOME (check & supply amount – **Must be Filed in Completely**)

INDIVIDUAL: $_____ SPOUSE: $_____ ☐Food Stamps $_____ ☐SSI $_____ Other $_____

☐SSDI $_____ ☐TANF $_____ ☐Child Support $_____ OSS $_____ ☐ Soc Sec $_____

TOTAL HOUSEHOLD INCOME	☐ Monthly $	☐ Annual $	# in HOUSEHOLD

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LifeStream Behavioral Center

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Name	Last	First	Middle

If name is changed, please complete information below:

Did you provide opportunity to update voter registration:? ☐YES ☐NO ☐Provided ☐Declined (Not Interested) ☐Already a registered voter

OCCUPATION	If minor, FATHER NAME EMPLOYER ADDRESS	HOW LONG	TELEPHONE #

SPOUSE OCCUPATION	If minor, MOTHER NAME EMPLOYER ADDRESS	HOW LONG	TELEPHONE #

RESPONSIBLE PARTY	MEDICARE #	MEDICAID #	POLICY #

INSURANCE COVERAGE: Company Name Group or Individual Name of Policy Holder Date Of Birth

PHARMACY BENEFIT: Company Name Plan Name Account Number

CONTACTS:

NAME	RELATION	RESPONSIBLE PARTY	GUARANTOR	EMERGENCY CONTACT	GUARDIAN

****** Proof of Income **MUST BE VERIFIED ANNUALLY** in order to qualify for financial assistance.

Please sign and date to attest that all the information provided is true and accurate.

_____ Consumer's Name (Please **PRINT**)

_____ _____

Signature of Consumer or Consumer Representative Date

_____ _____

Witness Signature Date