Westwood Behavioral Health Center, Inc.

DEMOGRAPHIC INFORMATION

Client Name (First, MI, Last)	Client No.	Today's Date

Address	City	State	Zip
Primary			
Local ☐ Same as Primary			
Billing ☐ Same as Primary			

County of Legal Residence ☐ Out of State ☐ Unknown

Home/Cell Phone	Work Phone	Email Address
( )	( )	

Where may we contact you?
☐ Primary Address ☐ Local Address ☐ Billing Address
☐ Home Phone ☐ Work Phone ☐ Other Phone

Where may we leave a message?
☐ Home ☐ Work
☐ Other:

Client Age	DOB (MM/DD/YYYY)	Gender	Soc. Sec. No.
	___ ___ / ___ ___ / ___ ___ ___ ___	☐ Male ☐ Female	

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Separated ☐ Other:

Race
☐ W - White ☐ N - Native Am. ☐ P - Native Hawaiian/Other Pacific Islander ☐ Multiple Race
☐ B - Black/African Am. ☐ A - Asian ☐ M -Alaskan Native ☐ Unknown

Ethnicity
☐ A - Puerto Rican ☐ B - Mexican ☐ C - Cuban ☐ D - Other Hispanic ☐ E - Not Hispanic or Latino

Parent/Guardian/Custodian if Minor (include name and address)	**Parent/Guardian/Custodian Phone**
	( )

Emergency Contact (name and address)	**Relationship**	**Emergency Contact Phone**
		( )

Primary Language	**Client needs the assistance of an interpreter?**
	☐ No ☐ Yes If yes: ☐ American Sign Language ☐ Language Interpreter (specify):

Client needs assistance with visualization of material or alternate format?
☐ No ☐ Yes

Advance Directive?
☐ Yes If yes, request a copy of the directive.
☐ No If no, ask if client needs assistance in obtaining an advance directive.

Payers

Medicaid ☐	Medicaid No.	Medicare ☐	Medicare No.

Insured Cardholder Name	S.S. Number	Place of Employment	Insured DOB

	Insurance Plan No.	Group No.
Primary Private Insurance		
Secondary Private Insurance		

☐ Workers Comp ☐ Veteran ☐ Self	Other (specify) ☐	Other (specify) ☐

EAP Involved/Eligible ☐	Company Name/Address/Phone