

Behavioral Health Department

**Patient Information**

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_

Current Address \_\_\_\_\_ City \_\_\_\_\_, CA Zip Code \_\_\_\_\_

Current phone number(\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Alt. phone (cell) (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ County of Birth \_\_\_\_\_

Is it okay to:  call home  send mail \_\_\_\_\_ @ \_\_\_\_\_  leave message

<b>RACE:</b>	<b>RELATIONSHIP STATUS:</b>
<input type="checkbox"/> Hispanic/Latin American	<input type="checkbox"/> Single (never been married)
<input type="checkbox"/> Asian/Asian American	<input type="checkbox"/> Married
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Separated
<input type="checkbox"/> White/European American	<input type="checkbox"/> Divorced
<input type="checkbox"/> Native American/Alaskan	<input type="checkbox"/> Cohabiting
<input type="checkbox"/> Other	<input type="checkbox"/> Committed same sex relationship

Name of spouse/partner \_\_\_\_\_

**Name and Date of Birth of dependants:**

<b>Name</b>	<b>Date of Birth</b>

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_