

## WESTERN HIGHLANDS NETWORK

**Consumer Demographic Registration – All information is required – Fax to 828-225-2779**

**Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Client:** \_\_\_\_\_

Last Name	First Name	Middle Name	Suffix	Maiden/Birth Last Name	Birth First Name
Social Security # _____ - _____ - _____		Date of Birth: ____ / ____ / ____		Male <input type="checkbox"/> Female <input type="checkbox"/>	Highest Grade Completed _____

Street Address and/or P.O. Box \_\_\_\_\_

City	State	Zip	County	Home Phone (including area code) (____) _____-____
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**English Proficiency:**  Yes  No If no language spoken: \_\_\_\_\_ **Referral Source:** \_\_\_\_\_

Please **check** the appropriate box for the following items: Are you a veteran?  Yes  No Are you pregnant?  Yes  No

**Race/Ethnic Background:**

1 <input type="checkbox"/> White/Caucasian/Non-Hispanic	2 <input type="checkbox"/> Black/Non-Hispanic	4 <input type="checkbox"/> Hispanic
3 <input type="checkbox"/> American Indian/Alaskan Native	6 <input type="checkbox"/> Unknown/Not Provided	5 <input type="checkbox"/> Multi-Ethnic
7 <input type="checkbox"/> Asian/Pacific Islander	8 <input type="checkbox"/> Other	

**Ethnicity:**

C <input type="checkbox"/> Hispanic, Cuban	H <input type="checkbox"/> Hispanic, Other	N <input type="checkbox"/> Not Hispanic Origin
M <input type="checkbox"/> Hispanic, Mexican American	P <input type="checkbox"/> Hispanic, Puerto Rican	

**Marital Status:**

1 <input type="checkbox"/> Single/Never Married	2 <input type="checkbox"/> Married	3 <input type="checkbox"/> Separated	4 <input type="checkbox"/> Divorced
5 <input type="checkbox"/> Annulled	6 <input type="checkbox"/> Widowed	8 <input type="checkbox"/> Domestic Partners	

**Health Related Codes:**  Tobacco use  Substance abuse  Both

**Living Arrangement:**

00 <input type="checkbox"/> Other	1 <input type="checkbox"/> Private Residence	8 <input type="checkbox"/> Nursing Home (ICF, SNF)
10 <input type="checkbox"/> Adult Care Home 6 or fewer beds	11 <input type="checkbox"/> Community ICF-MR	12 <input type="checkbox"/> Community ICF-MR 70+ beds
13 <input type="checkbox"/> Homeless	14 <input type="checkbox"/> Correctional Facility	15 <input type="checkbox"/> Institution
16 <input type="checkbox"/> Residential Facility/Not Nursing Hm	17 <input type="checkbox"/> Foster/Alternative Family Lvng	18 <input type="checkbox"/> Other Independent
19 <input type="checkbox"/> Adult Care 7+ beds (Rest Home)		

**Legal Guardian Name:** (If applicable) \_\_\_\_\_

Address	City	State	Zip	Phone (including area code) (____) _____-____
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**Emergency Contact:** \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_-\_\_\_\_

Name	Relationship	Phone (including area code)
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Do you have Medicaid?  Yes  No If yes, Medicaid # \_\_\_\_\_ Effective Date: \_\_\_\_\_

Do you have Medicare?  Yes  No If yes, Medicare # \_\_\_\_\_ Effective Date: \_\_\_\_\_

Do you have North Carolina Health Choice (NCHC)? Policy ID # \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Employment Status:**

<input type="checkbox"/> Full time	<input type="checkbox"/> Part time	<input type="checkbox"/> Unemployed	<input type="checkbox"/> Student
<input type="checkbox"/> Retired	<input type="checkbox"/> Homemaker	<input type="checkbox"/> Armed Forces	<input type="checkbox"/> Seasonal/Migrant Worker

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Axis type: "B" = Principle/Primary Dx. (list only 1) "R" = Other Primary Dx. (list as many as are being treated)  
 "A" = Additional Dx. (Not being treated)

**revised 07/05/06**