REPLACEMENT NARCOTIC THERAPY ADMISSION

Patient Section

Clinic ______

A. Name, Identification and Contact Information

1. Legal Name ______ First Name ______ Last Name ______ Middle Name ______ Suffix (Jr, Sr. etc) ______ Nickname / Preferred

2. Date of Birth ______ 3. Gender ☐ Male ☐ Female 4. Aliases ______

5. Social Sec No ______ 6. Driver License ______ Number ______ State

7. Home Address ______ Street Address ______ City ______ State ______ Zip Code

8. Home Phone ______ 9. Cell Phone ______ 10. Email ______

11. Eye Color ______ 12. Hair Color ______ 13. Mother's Maiden Name ______

14. Referred By ☐ Self Referral ☐ Friends / Family ☐ Internet Search ☐ Doctor/Health Care Provider ☐ School / College ☐ 12 Step ☐ Hospital ☐ Employer / EAP ☐ Provider Directory ☐ Other Alcohol/Drug Program ☐ Other/Community/Legal

15. Race ☐ White ☐ Alaskan Native ☐ Chinese ☐ Guamanian ☐ Japanese ☐ Laotian ☐ Vietnamese ☐ African American ☐ Asian Indian ☐ Filipino ☐ Hawaiian ☐ Korean ☐ Samoan ☐ Other Asian ☐ American Indian ☐ Cambodian ☐ Mixes ☐ Other Race

16. Tattoos ______

17. Distinguishing Marks ______

B. Emergency Contact and Primary Physician

1. Contact Name ______ First Name ______ Last Name

2. Contact Address ______ 3a. Home Phone ______

______ City ______ State ______ Zip 3b. Cell Phone ______

4. Relationship ☐ Spouse ☐ Family Member ☐ Friend ☐ Guardian ☐ Coworker ☐ Other ______

5. Primary Physician ______ 6. Phone ______

C. Financial / Employment Status

1. Method of Payment ☐ Self-Pay / Cash ☐ Medi-Cal ☐ Insurance ☐ VA ☐ County/Prop36 ☐ Other______

2. If Medi-Cal, enter CIN Number ______

3. If Insurance, complete following: Insurance Carrier ______

Member No ______ Group No. ______

4. Employment status ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Unemployed(Not seeking) ☐ Never worked ☐ Volunteer ☐ Retired

Employer Name ______ Work Phone ______

Employer Address ______

5. Are you enrolled in School ☐ Yes ☐ No

School Name ______ Program / Major ______

I certify that the information provided above is accurate to the best of my knowledge.

Patient Signature ______ Date ______

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