STEPPING STONE OF BOONE

Patient ID:
Date:

New Patient Form

First Name:________________________________Last Name:__________________________________Maiden:____________

Phone #:____________________________Gender:_______Soc Sec #:_______-________-__________Pregnant:____________

Birth Date: ______/_____/____________Preferred Language:_______________________________

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Marital Status: ☐ Annulled ☐ Divorced ☐ Domestic Partner ☐ Married ☐ Separated ☐ Never Married

Height:________ Weight:_______Hair Color: ___________ Eye Color: ______________ Education level:________________

Race: ☐ Asian ☐ Black/African American ☐ Multiracial ☐ Pacific Islander ☐ White ☐ Other

Employment: ☐ Armed Forces/National Guard ☐ Full-time ☐ Part-time ☐ Homemaker

☐ Not available for work ☐ Retired ☐ Student ☐ Seasonal/Migrant

Emergency Contact: ________________________phone number:_____________________relationship:________________

Living Arrangement: ☐ Homeless ☐ Dorm/ Military housing ☐ Private residence ☐ Hospitality House

Physical Address:____ City:________________ State:_____ Zip:_____________

Mailing Address:____ City:________________ State:_____ Zip:_____________

in Household: ______________ Household Annual Income: ________________________ Veteran:_________________

Who Served in Active Duty: ☐ Self ☐ Parent ☐ Grandparent ☐ Sibling ☐ Spouse ☐ Partner ☐ Child

☐ Other Significant Person ☐ N/A Which War: ☐ OIF ('03-present) ☐ OEF (01'-present) ☐ Other war

Number of Arrests in the last 30 days:________________ Traumatic Brain Injury:_______________

Primary Health/ Medical Insurance:____

Do you have Advance Directives (i.e. living will and durable power of attorney for healthcare)? ☐ yes ☐ no

If so, who is your power of attorney? ____

Have you been in treatment for addiction before? ☐ yes ☐ no

If so, where?____

When?____

How did you hear about us?:____