CARROLL COUNTY HEALTH DEPARTMENT
BUREAU OF PREVENTION, WELLNESS & RECOVERY
REGISTRATION FORM

Name:
First_____ Middle_____ Last_____

Address_____

City_____ Zip Code_____

Home Phone_____ Cell Phone_____

Social Security Number_____ Sex: Male ❑ Female ❑

Date of Birth_____ Age_____ Marital Status ❑ NM ❑ M ❑ D ❑ Sep ❑ Widow

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

❑ Native Hawaiian or other Pacific Islander ❑ White

Are you Hispanic or Latino? ❑ Yes ❑ No Citizenship_____

Formal Education Completed_____ ❑ Diploma ❑ GED ❑ AA Degree ❑ BA Degree ❑ MA Degree

Veteran Status _____

Are you Pregnant? ❑ Yes ❑ No Primary Language_____ Interpreter Needed ❑ Yes ❑ No

❑ Unemployed ❑ Employed ❑ FT ❑ PT by: _____

Monthly Income $_____ Number of dependents (including self) _____

Emergency Contact Person –

Name: _____ Relationship_____

Address: _____ Phone:_____

Are you currently in treatment? ❑ Yes ❑ No Where?: _____

Primary Drug of Choice_____ ❑ Injected ❑ Smoked ❑ By Mouth ❑ Snorted

Source of Referral_____ Are you Court Ordered? ❑ Yes ❑ No

Do you have a regular medical doctor? Name: _____

Do you have a regular dentist? Name: _____

Check any that apply: Temporary Cash Assistance ❑ Medicare ❑ Medicaid ❑ None ❑

Health Insurance ❑ Insurance Carrier_____

_____

Signature Date