SMH MEMORY DISORDER CLINIC **Appt. Date**_____

Patient: _____ **Client SS:** _____-_____-_____ **Phone:** _____
(Last) (First) (MI)
PermanentAddress: _____
(Street) (City) (State) (Zip Code)
Alternate Address: _____
(Street) (City) (State) (Zip Code)
***Contact (if other than patient)** _____ **Rel.** _____ **Phone**_____

Date of Birth: _____ **Age:** ____ **Place of Birth** _____
(City) (State)
Marital Status: __Divorced __ Married __Separated __Single (never married) __Widowed

Gender: ____ male _____female **Primary Language** _____

Driving: _____ yes _____ no

Is patient a veteran: _____yes _____no **Is patient's spouse a veteran:** _____yes_____no

Race:
__ Asian/Pacific Islander
__ Black
__ Native American
__ Other
__ White

Ethnicity:
__ Hispanic
__ Non-Hispanic

Other Information:
__ Uninsured
__ Primary address is out of state

Do you need information on how to pay for care?
___ Yes
___ No

Client's Living Arrangement
__ Lives Alone
__ With Spouse and Children
__ With Spouse Only
__ With Children Only
__ With Parent
__ With Other Relative
__ With Non Relative
__ With Paid Caregiver

Place of residence
__ Private residence
__ Independent Retirement Community
__ Assisted Living
__ Adult Congregated Living/Adult Foster Home
__ Residential Treatment Facility Group Home
__ Nursing Home
- Name of Community_____
  Facility Contact/ phone # _____

Primary Care Physician: _____
Address: _____
Phone: _____ **Fax** _____

List all services currently being used (and provide agency name)

_____Adult Day Care _____
_____In-Home Health _____
_____Companion Service _____
_____Lifeline _____
_____Home Delivered Meals _____
____ Attending Senior Center _____
____ Care Manager _____
_____Guardian _____
_____VA services _____

Are you currently registered for the Brain Bank? ___Yes ___ No Other Research? ___ Yes ___ No
Would you like information regarding the Brain Bank? ___Yes ___No
Do you have a Durable Power of Attorney? ____Yes ___No Name: _____

Primary Caregiver Information

Primary Caregiver Name _____
(Last) (First) (Middle Initial)
Phone no.: _____ / _____ **Alternate Phone no**: _____ / _____

Address: _____
(Street) (City) (State) (Zip Code) (County)

Caregiver Age: _____ Date of Birth: _____ **Gender:** ____ Male ____ Female

Relationship to client: ___ Spouse ___ Child __Sibling __Other Relative ___ Neighbor/friend ___ other

Caregiver Paid? ___Yes ___No

Caregiver Marital Status:	**Race**	**Ethnicity**
__ Divorced	___Asian/Pacific Islander	___Hispanic
__ Married	___Black	___Non-Hispanic
__ Separated	___Native American/Alaskan	
__ Single (Never married)	___Other	
__ Widowed	___White	**Caregiver Primary Language**_____

Emergency Contact (other than caregiver)

Relative Name: _____ **Relationship to client**: _____

Address: _____

Phone no: _____ / _____ **Alternate Phone no**: _____/_____

Additional Family Member Information (other than caregiver)

Relative Name: _____ **Relationship to client**: _____

Address: _____

Phone no: _____ / _____ **Alternate Phone no**: _____ / _____

Insurance Information:

Medicare ID #: _____ **Coverage (circle) A B**

Secondary Insurance Company: _____ **ID #:** _____
OR
Medicare Advantage: _____ **ID #:** _____

Claims Address: _____

Does your insurance require Prior Authorization? ____Yes _____No