CLIENT INFORMATION /REGISTRATION

Please complete this form, we appreciate your effort to complete it in full, JFS is a non-profit and client Demographics allows us to apply and receive grants to support our programs. All information is confidential and protected by HIPAA.

Today's Date:	Client's Name:		
Social Security Number:	Date of Birth:	Gender: ☐Female ☐Male ☐Not Listed	Preferred Language: ☐English ☐Spanish ☐Other: _____
Home Address:			
Cellphone Number:	Cellphone Provider:	Home Telephone Number:	E-Mail Address:
Emergency Contact Name:		Relationship to Client:	Emergency Contact Phone Number:

Ethnicity: ☐Hispanic or Latino ☐Non Hispanic or Latino	Race: ☐American Native /Alaska Native ☐Asian ☐Black/African American ☐Native Hawaiian/Other Pacific Islander ☐White ☐Other:_____
Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed ☐Living with Someone ☐N/A	Sexual Orientation: ☐Heterosexual/Straight ☐Homosexual/Gay/Lesbian ☐Bi-Sexual ☐Other:_____
Estimated Annual Income:	Religion: ☐Jewish ☐Non Jewish ☐Other: _____

Name Parent /Guardian 1 (Minors Only):	Name Parent/Guardian 2 (Minors Only):
Telephone Number:	Telephone Number:
Home Address (if different):	Home Address (if different):

Medical Insurance Name:		Insurance ID:
Family Doctor's Name:		Family Doctor's Telephone Number:
Other Mental Health Treatment(s)?: ☐Yes ☐No	If Yes, with whom:	Date(s):
Do you already have an Advanced Health Care Directive? ☐Yes ☐No		If you would like to create one visit the website below: *http://oag.ca.gov/search-results/?query=advance+directive*
Medications Currently Being Taken:		
State Client's Problems Briefly:		
Where did you learn about JFS:		

All Information is true to the best of my knowledge. I authorize JFS to contact me via email, text, telephone and regular mail.

☐ I opt out to be notified about appointments via text and or email.

Name of Person Completing Form:	Signature: