ALT Recovery Group
A New Way Forward

NEW PATIENT CONTACT / REGISTRATION FORM

PATIENT'S LAST NAME	FIRST	MIDDLE

SOCIAL SECURITY #	GENDER	RACE
	M / F / Other	Hispanic / Caucasian / African American / Other / Unknown

MARITAL STATUS
Single/ Married/ Separated/ Divorced/ Significant Other/ Widowed/ Cohabitation/ Unknown/

DATE OF BIRTH	AGE	EMPLOYMENT STATUS	OCCUPATION
		Employed/ Unemployed/ Disabled/ Student/	

STREET ADDRESS / P.O. BOX	CITY	STATE	ZIP CODE

CELL PHONE #	HOME PHONE #	EMAIL

May we contact you with all 3 communication means? ***YES NO***

If not, which one(s) do your prefer? *Circle choices.* ***Cell Home Email***

HAIR COLOR	EYE COLOR	WEIGHT	HEIGHT
Brown/ Black/ Red/ Blonde/ Grey	Brown / Hazel / Blue / Green		

Picture ID submitted for copy? ***YES NO***

EMERGENCY CONTACT NAME	PHONE #	RELATIONSHIP TO PATIENT

May we leave a message with this person? ***YES NO***

Which medication assisted treatment (MAT) for opioid use disorders (OUD) are you interested in? Circle choice below.
Methadone Buprenorphine/Suboxone Naltrexone/Vivitrol **Not sure**

How will you pay for our services? Circle choice below.
Self pay (cash or credit card) Medicaid Medicare Private Insurance

How did you hear about us? Circle choice below. Be specific if between parentheses ( ).
Internet / Radio / Ad (newspaper or magazine) / Friend or Relative / Hospital ER / Other Healthcare Provider
Jail-Prison / Probation-Parole Office / Drug Court / Outreach Event ( ) / Other ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any billing balance regarding my patient account with the ALT Recovery Group Clinics.

Patient Signature Date

Revised 10/05/17