SMH MEMORY DISORDER CLINIC

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** _____

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: _____

Preferred Pharmacy: _____

Pharmacy Address: _____

Health Insurance Information:

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

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

Claims Address: _____

Prescription Insurance Information:

Company: _____
ID# _____
Claims Address: _____

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

Emergency Contact (other than caregiver)

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

Address: _____

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