Phone: 602-424-2060
Fax: 602-424-1623

Native American Connections

Return to:
intake@nativeconnections.org

Client Registration Form

Please provide client information or personal information if self-referring.

Date of Referral:

Self Referral:
☐ Yes

First Name: **Last Name:** **Initial:** **Preferred Name:** **Date of Birth:**

AHCCCS ID #: **Other insurance:** **Mother's Maiden Name:**

Primary Care Provider: **Primary Care Provider Address:** **Primary Care Provider Phone:**

Social Security #:

Ethnicity: Hispanic or Latino(a)
☐ No
☐ Yes

Preferred Pronouns:

Are you currently pregnant?
☐ No
☐ Yes,

Gender Identity:

Cis Gender:
☐ Male
☐ Female

Expected Due Date:

Base Race:
☐ American Indian
☐ Asian or Pacific Islander
☐ Black or African American
☐ Caucasian
☐ Native Hawaiian
☐ Not provided
☐ Pacific Islander

Marital Status:
☐ Divorced
☐ Legally Separated
☐ Married
☐ Separated
☐ Single
☐ Domestic Partnership (not married)
☐ Widow

Are you an enrolled Tribal Member?
☐ Yes
☐ No

Tribal Affiliation:

Sexual Orientation: ☐ Asexual ☐ Bisexual ☐ Decline ☐ Gay ☐ Heterosexual ☐ Lesbian ☐ N/A due to age ☐ Questioning

Military Status: ☐ Active Military ☐ Disabled Veteran ☐ Retired Veteran ☐ Veteran ☐ No Active or Veteran

Homeless:
☐ Yes

Physical Address: **City:** **State:** **Zip Code:**

Mailing Address: **City:** **State:** **Zip Code:**

Cell Phone: **Allow Text Message:** ☐ Yes: **Message Phone:**

Home Phone: **Email:**

Contact status: ☐ All communication allowed ☐ No mail communication ☐ No phone communication

Currently living in NAC housing? ☐ No ☐ Yes Which property:

Current legal involvement? *If yes, describe:* ☐ No ☐ Yes

Registered sex offender? ☐ No ☐ Yes

Continue to page 2

Native American Connections

Currently receiving psychiatric/behavioral health services? ☐ Yes ☐ No

If Yes, Provide Treatment / Clinic Info:

Currently receiving MAT (Medication- Assisted Treatment) Services? ☐ Yes ☐ No

If Yes, Provide Next Appointment Date, Provider Info, Location/Address:

Which services are you interested in receiving?

☐ Residential SA Treatment ☐ Intensive Outpatient ☐ Individual/group counseling ☐ Medical Services
☐ Psychiatric Services ☐ MAT (Medication-Assisted Treatment) Services

Smoking status (Required):

☐ current every day smoker ☐ current some-day smoker ☐ former smoker ☐ never smoked ☐ unknown status

Substance Use History (Required): *Please list full history of substance use and provide indicated details.*

Substance name:	**Date of Last Use:**	**Amount used:**	**Route of use (IV, smoking,etc):**
Substance name:	**Date of Last Use:**	**Amount used:**	**Route of use (IV, smoking,etc):**
Substance name:	**Date of Last Use:**	**Amount used:**	**Route of use (IV, smoking,etc):**
Substance name:	**Date of Last Use:**	**Amount used:**	**Route of use (IV, smoking,etc):**
Substance name:	**Date of Last Use:**	**Amount used:**	**Route of use (IV, smoking,etc):**

Client Emergency Contact

First Name:	Last Name:	Relation:	Address:	Phone:

Referring Agency Info & Point of Contact

Referral Agency/ Site:	**Point of Contact Name:**	**Point of Contact Phone:**	**Point of Contact Email:**