Hometown- Patient Registration Form

A member of Carolina Health Centers Inc.

Patient's Demographic information **PT Acct #**_____

Patient's Name:_____ Birthday:_____

First Middle Last Month, Day, Year

What is the best contact # to leave messages about appointments, lab results, etc?

Name # Relationship

Patient's Social Security #:_____ Sex: **Male Female Other**

Address: _____

City, State Zip County

School/ Daycare:_____

Race/Ethnicity/ SOGI/ Language

Race: **Black/ African American Asian American Indian/Pacific Islander White**

Ethnicity: **Hispanic Non-Hispanic Unknown**

Gender Identitty: **Male Female Transgender Female (M to F) Transgender Male (F toM)**

Choose Not to Disclose Non-binary/genderqueer Questioning

Preferred Pronoun: **He/ Him She/Her We/Them**

Sexual Orientation: **Lesbian/Gay Straight Bisexual Something Else**

Don't Know Choose Not To Disclose

Homeless: **Yes No**

Primary Language: **English Spanish Other:**_____

Are there any impairments or communication barriers that we need to be aware of?

_____

Patient's Preferred Primary Care Provider (Please circle one)

Dr. Ashley Jenkins Dr. Daniel Lapp Dr. Cassandra Saunders

Stephanie Schafer, APRN

Parents/Guardians this section is YOUR information

Parent 1:_____

Cell#:_____ Work #_____

Email:_____ Social Security #_____

Address:_____

How do you prefer to be contacted? (please circle one) **CALL TEXT EMAIL**

Parent 2:_____

Cell#:_____ Work # _____

Email:_____ Socail Security #_____

Address:_____

How do you prefer to be contacted? (please circle one) **CALL TEXT EMAIL**

In case of an emergency who should we contact?

Name **Number** **Relationship**

Patient's Insurance Information

If your child is covered by Medicaid which plan are they covered by? (cirlce the plan that applies)

Select Health **Molina** **WellCare** **Absolute Total Care** **Healthy Blue**

Insurance ID #_____

When did this plan become active coverage for your child?_____

If your child has private insurance coverage which plan covers them? (circle or list below)

BCBS **Cigna** **Other:**

Insurance ID or group #_____

When did this plan become active coverage?_____

Who is the primary card holder:_____

Relationship to Patient

Cardholders Date of Birth: Sex: **Male** **Female**

Does your child have a secondary insurance coverage? **YES** **NO**

If yes, what plan is the secondary coverage?_____

Secondary Coverage ID or group #_____

When did the secondary coverage become active?_____

Who is the primary card holder?_____

Relationship to Patient

Cardholders Date of Birth:_____ Sex: **Male** **Female**

Sliding Fee Scale Information: We are required to charge for all services. However, charges may be adjusted according to your income and the number of family members that reside in the home.

☐ **Yes**- I would like an application for the sliding fee scale.

☐ **No**- I do not wish to apply for the sliding fee scale at this time.

How many members reside in the home?_____

Annual Household Income?_____

Homeless: **YES** **NO**

HIPAA

I understand and comply with Carolina Helath Centers, Inc copy of its Privacy Notice, which explains how my child's health information will be handled in various situations.

I also choose to disclose my child's information to the following individuals:

Name:	Contact #:
Name:	Contact #:
Name:	Contact #:

Signatures of Parent or Patient's who are 16 and older **Date**