Community Health of East Tennessee, Inc. 130 Independence Lane, LaFollette, TN 37766 (423)562-1705

**PATIENT REGISTRATION FORM**

Date:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **PATIENT INFORMATION PLEASE COMPLETE (fill out) entire form in Black or Blue Pen Only** | | | | | | | |
| LAST NAME FIRST NAME MI | | | | | | | |
| STREET ADDRESS CITY STATE ZIP | | | | | | | |
| SOCIAL SECURITY # | | DATE OF BIRTH | HOME PHONE | | DAY PHONE | | |
| CELL PHONE (working numbers only) | | WORK PHONE | EMAIL ADDRESS | | **Are You a U.S. Veteran**?  🞎 Yes 🞎 No | | |
| **MARITAL STATUS**  🞎 Single 🞎 Married 🞎 Divorced  🞎 Separated 🞎 Widowed  Spouse’s  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Are You Homeless?** 🞎 YES 🞎 No  If homeless, are you: 🞎 Doubling Up (living with others) 🞎 Shelter  🞎 Street 🞎 Transitional 🞎 Unknown | | | | | Which County District do you live in? 1st, 2nd, 3rd, 4th, 5th |
| **Preferred Language** if Not English: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Primary Language, if Not English: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Do you Need interpreter Services: □ Yes □ No | | | | | **Which best describes the patient's Activity Level below:**  □ Patient has little or no exercise  □ Patient is Lightly Active  □ Patient is Moderately Active  □ Patient is very Active |
| **Choose a Primary Care Provider** –**Circle One:**  Dr. John Burrell Mary Morris, CFNP  Jeffrey Mann, DO April Bryant, CFNP  Teresa Rasmussen, PA-C Emily Tamer, PA-C  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Ethnicity/Ethnic Origin**:  🞎 Hispanic 🞎 Non-Hispanic | | **GENDER at Birth**  🞎 MALE 🞎 FEMALE   |  | | --- | | **Ages 18 and Older - Sexual Orientation**  □ Lesbian or gay  □ Straight (not lesbian or gay)  □ Bisexual  □ Something else  □ Don't Know  □ Choose not to disclose **GENDER**  **IDENTITY - Ages 18 & older**  □ Male □ Female □ Other  □ Transgender Male/Female-to-Male  □ Transgender Female/ Male-to-Female  □ Choose not to disclose | | | |
| **How is patient transported here?**  ***□*** Brought by Family/Friend ***□*** Walks ***□*** Cab  ***□*** Drives Self ***□*** ETHRA  ***□*** Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **RACE**  🞎 Caucasian/White  🞎 Black/African-American  🞎 Asian  🞎 Native Hawaiian  🞎 American Indian/Alaska Native  🞎 Other Pacific Islander  🞎 More than one race  🞎 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **Check one:**  🞎 Patient currently has Medical Insurance (see below)  🞎 Patient currently DOES NOT have Medical Insurance  🞎 Would like to apply for the SLIDING-FEE Discount; available for uninsured **and** patients with insurance who are low income | | ***For Staff Use Only:***  ***□ Token provided for portal***  ***□ Patient given brochure***  ***□ Patient given Com.Resources***  ***□ New Patient Orientation***  ***□ Old Records received (Hamwi)***  ***□ Privacy Notice date updated***  ***□ Paperwork complete*** |
| EMPLOYER | | Patients Occupation | | Is your visit today work-related , automobile or other accident related?  🞎 Yes 🞎 No If so, Date of Injury\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **RESPONSIBLE PARTY INFORMATION** | | | | | | | |
| 🞎 **Patient** (18 years or older) 🞎 **Custodial Parent**  🞎 **Guardian** (Proof of legal status required for treatment)  🞎 **Foster Parent** (Proof of legal status required for treatment) \*Please list Legal Guardian (if not patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |
| LAST NAME FIRST NAME MI | | | | | | DATE OF BIRTH | |
| STREET ADDRESS CITY STATE ZIP | | | | | | SOCIAL SECURITY# | |
| EMPLOYER | EMPLOYER PHONE | | HOME PHONE | | CELL PHONE | | |
| **PRIMARY MEDICAL INSURANCE INFORMATION** | | | **SECONDARY INSURANCE INFORMATION** | | | | |
| Medical Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Medical Insurance Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Birth Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| As a Health Center that receives Federal Funding, we are required to collect the following information. All answers are confidential.  Number of People Living in Household? \_\_\_\_ **Estimated Monthly** Income for Household (CIRCLE ONE)   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | $0-$900 | $901-$1,300 | $1,301-$1,500 | $1,501-$1,800 | $1,801-$2,100 | $2,101-$2,500 | | $2,501-$3,000 | $3,001-$3,500 | $3,501-$4,000 | $4,001-$4,500 | $4,501-$5,000 | $5,000 & over | | | | | | | | |
| **EMERGENCY CONTACT** | | | | | | | |
| NAME RELATIONSHIP TO PATIENT PHONE NUMBER | | | | | | | |

I Understand and agree that regardless of insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read and certify that this information is correct. I will notify this office of changes.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rev2/18