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

 **PATIENT REGISTRATION FORM**

Date:

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| **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 🞎 NoIf 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, CFNPTeresa Rasmussen, PA-C Emily Tamer, PA-COther \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Ethnicity/Ethnic Origin**: 🞎 Hispanic 🞎 Non-Hispanic | **GENDER at Birth** 🞎 MALE 🞎 FEMALE

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| **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 |

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| **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)

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| --- | --- | --- | --- | --- | --- |
| $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 |

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| **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