RETURN ALL DOCUMENTS TO FRONT OFFICE

Office Staff:

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

Date:

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PLEASE COMPLETE (fill out) entire form in Black or Blue Pen Only

LAST NAME | FIRST NAME | MI | Preferred Name:

STREET ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY # | DATE OF BIRTH | HOME PHONE | DAY PHONE

CELL PHONE (working numbers only) | WORK PHONE | EMAIL ADDRESS

MARITAL STATUS

☐ Single ☐ Married ☐ Divorced
☐ Separated ☐ Widowed

Spouse's Name ____________________________

Which pharmacy do you use:

Can our office Text your cell phone with appointment reminders/Alerts?

Yes / No

Authorized Cell Number for Texting appoint Information:

____

Choose a Primary Care Provider –Circle One:

Dr. John Burrell
Mary Morris, FNP
Dr. Shaan Valji
Emily Tamer, PA
Hannah Echols, FNP
Dr. Megan Hall

Other ________________________

Do you Need Interpreter Services?

☐ Yes ☐ No

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

Who referred you to our clinic?

☐ **Self** ☐ **Friend/Family**

☐ **Other Physician; If physician please list**

Name:____________________________

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

How is patient transported here?

☐ Drives Self
☐ Brought by Family/Friend
☐ Walks
☐ Cab
☐ ETHRA
☐ Other ____________________

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

Medical Insurance Name:____
Policy Number: ____
Group Number: ____
Policy Holder's Name:____
Policy Holder's Birth Date:____
Policy Holder's Employer: ____

SECONDARY INSURANCE INFORMATION

Medical Insurance Name:____
Policy Number: ____
Group Number: ____
Policy Holder's Name:____
Policy Holder's Birth Date:____
Policy Holder's Employer: ____

EMERGENCY CONTACT

NAME | RELATIONSHIP TO PATIENT | PHONE NUMBER | ADDRESS

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___________________________

PATIENT NAME ________________________________
Head of Household (if different from patient):
____

DOB____

As a Health Center that receives Federal Funding, we are required to collect the following information. All answers are confidential.

Please circle the annual income that fits your household - ***HOUSEHOLD OF ____?***

1 in house	2 in house	3 in house	4 in house	5 in house	6 in house
Only circle one	Only circle one	Only circle one	Only circle one	Only circle one	Only circle one
0-$13,590	$0-$18,310	$0-$23,030	$0-$27,750	$0-$32,470	$0-$37,190
$13,591- $20,385	$18,311-$27,465	$23,031-$34,545	$27,751-$41,625	$32,471-$48,705	$37,191-$55,785
$20,386-$27,180	$27,466-$36,620	$34,546-$46,060	$41,626-$55,500	$48,706-$64,940	$55,786-$74,380
➢ $27,181	>$36,621	>$46,061	>$55,501	>$64,941	$74,381 & over

THE REPORTING OF YOUR INCOME ALLOWS US TO RETAIN OUR FEDERAL FUNDING AND EXPAND SERVICES..

Do you have Medicaid/TennCare? ☐ ***Yes*** ☐ ***No***

Are you a Veteran? ☐ Yes ☐No

Check your race: ☐ White ☐Black ☐Asian ☐American-Indian ☐Other ☐ Native Hawaiian ☐More than one race ☐ Other Pacific Islander

Are you Hispanic? ☐ Yes ☐No ☐ Choose Not to Answer

Primary Language ☐ English ☐ Spanish ☐Other list______________________

Are you Homeless ? ☐ Yes ☐No ☐ living with others ☐ Shelter ☐ Street ☐ Transitional

Do you think of yourself as:

☐ Straight/Heterosexual ☐ Gay/Lesbian ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ Choose not to answer

What is your current gender identity? (Check all that apply)

☐ Male ☐ Female ☐ Transgender to male ☐ Transgender to female ☐ Decline to Answer ☐ Other

What sex were you assigned on your birth certificate?

☐ Male ☐ Female

Initials (Patient) ____________ Initials (CHET Emp)__________ Date________________