| Today's Date: | **CCHS PATIENT REGISTRATION FORM** | Chart #: |
|---|---|---|
| Patient's Name: | Birth Date: | Age: |

Address: City: State: Zip:

| Social Security #: | Home Phone#: | Cell#: | E-Mail: |
|---|---|---|---|

**We may send text messages and/or emails for appointment reminders or service offerings**. Don't text/email me □

Occupation: Employer: Employer Phone#:

**Marital Status:** □ Single □Married □ Divorced □ Widowed

**Homeless?** □ No □Living with someone else/Doubling up □ Shelter □ Street □ In Transition

**Race:** □ White □Black/African American □ American Indian □Asian □Other_____

**Ethnicity:** □Non-Hispanic □Hispanic/Latino □ Prefer not to report

**Language:** □English □Spanish □ Other: _____

**Gender:** □Male □Female □Transgender/M-to-F □Transgender/F-to-M □Other □Decline to report

**Sexual Orientation:** □Straight □Homosexual □Bisexual □Other □Don't know □Decline to report

**Veteran:** □Yes □No

**Family size _____ Annual income** $_____ **Do you want to be assessed for sliding fee discounts? □Yes □No**

| Who is your Primary Doctor? | Preferred Pharmacy? |
|---|---|

**PARENT/GUARDIAN INFORMATION – Please complete if patient is under 18 years of age**

| Mother's Name: | DOB: | Phone: |
|---|---|---|
| Father's Name: | DOB: | Phone: |
| **Guardian's Name(s): | DOB: | Phone: |

**If guardian, have you provided legal guardianship paperwork to CCHS? □Yes □No

**INSURANCE INFORMATION**

| Person responsible for bill: | Birth date: | Address (if different): | Home phone #: |
|---|---|---|---|
| Occupation: | Employer: | Employer address: | Employer phone #: |

Please indicate primary insurance: □ Private Insurance (type):_____(Ex: Blue Cross Blue Shield)

□ Medicare – Traditional □ Medicare – HMO / Advantage (Type)_____ (Ex: Humana Gold)

□ Tri-Care □ TennCare (type): _____ □ None (Self Pay) □ Sliding Fee INSURANCE ID:_____

Name of secondary insurance (if applicable):

**IN CASE OF EMERGENCY**

| Emergency Contacts: | Relationship: | Home phone #: | Work phone #: |
|---|---|---|---|
| | | | |

| Do you have a living will? □Yes □No | Do you want more information about:<br>Living Wills? □Yes □No<br>Durable Power of Attorney? □Yes □No<br>Declaration for Mental Health Treatment? □Yes □No |
|---|---|
| Do you have a Declaration for Mental Health Treatment? □Yes □No | |
| Employee: Literature given? □Yes □No | Employee Signature: |

Completed by: □ Self □ Mother □ Father □ Guardian □Other: _____