Patient's Name: Birth Date: State: Zip:	Today's Date:	CCHS	CCHS PATIENT REGISTRATION FORM			Chart #:	
Social Security #: Home Phone#: Cell#: E-Mail:	Patient's Name:		Birth Date:		Age:	Age:	
We may send text messages and/or emails for appointment reminders or service offerings. Don't text/email me U Occupation:	Address: Ci			ty:	State: Zip:		
Coccupation: Employer: Employer Phone#: Marital Status: Single	Social Security #: Home Phone#:			Cell#: E-Mail:			
Marital Status:	We may send text messages and/or emails for appointment reminders or service offerings. Don't text/email me						
Homeless?	Occupation:	Employer:		Employer Phone#:			
Race:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed						
Ethnicity:	Homeless? □ No □Living with someone else/Doubling up □ Shelter □ Street □ In Transition						
Canguage: English Spanish Other:	Race: White Black/African American American Indian Other						
Gender: Male Female	Ethnicity: Non-Hispanic Hispanic/Latino Prefer not to report						
Sexual Orientation: Straight							
Veteran:							
### 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: Phone:		<u> </u>	I □B	isexual □Other □Do	on't know □□	ecline to report	
Who is your Primary Doctor? PARENT/GUARDIAN INFORMATION — Please complete if patient is under 18 years of age Mother's Name: DOB: Phone: Ph							
Mother's Name: DOB:							
Mother's Name: Father's Name: Father's Name: Phone: Father's Name: Phone: Phone							
Father's Name: DOB: Phone: Phone:							
**Guardian's Name(s): **If guardian, have you provided legal guardianship paperwork to CCHS?							
**If guardian, have you provided legal guardianship paperwork to CCHS?							
Person responsible for bill: Coccupation: Employer: Employer address: Employer address: Employer phone #: Please indicate primary insurance: Private Insurance (type):		ovided legal guardian	shin nane				
Person responsible for bill: Address (if different): Birth date: Address (if different): Employer address: Employer phone #: Please indicate primary insurance: Private Insurance (type):							
bill: Address (Ir different): Home pnone #:							
Occupation: Employer: Employer address: Employer phone #: Please indicate primary insurance: Private Insurance (type):		Birth date:	Address	(if different):	Home ph	Home phone #:	
Please indicate primary insurance: Private Insurance (type):	DIII:						
Please indicate primary insurance: Private Insurance (type):							
Please indicate primary insurance: Private Insurance (type):	Occupation:	Employer:	Employe	er address:	Employe	Employer phone #:	
□ 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: Living Wills? □ Yes □ No Durable Power of Attorney? □ Yes □ No Declaration for Mental Health Treatment? □ Yes □ No Employee: Literature given? □ Yes □ No Employee Signature: Employee Signature:	•	' '	, , , , , , , , , , , , , , , , , , , ,		' '		
□ 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: Living Wills? □ Yes □ No Durable Power of Attorney? □ Yes □ No Declaration for Mental Health Treatment? □ Yes □ No Employee: Literature given? □ Yes □ No Employee Signature: Employee Signature:							
Tri-Care TennCare (type):	Please indicate primary insurance: Private Insurance (type): (Ex: Blue Cross Blue Shield)						
Name of secondary insurance (if applicable): IN CASE OF EMERGENCY	□ Medicare − Traditional □ Medicare − HMO / Advantage (Type) (Ex: Humana Gold)						
IN CASE OF EMERGENCY Emergency Contacts: Relationship: Home phone #: Work phone #: Do you have a living will?	□ Tri-Care □ TennCare (type): □ None (Self Pay) □ Sliding Fee INSURANCE ID:						
Emergency Contacts: Relationship: Home phone #: Work phone #: Do you have a living will?	Name of secondary insurance (if applicable):						
Do you have a living will?	IN CASE OF EMERGENCY						
Do you have a Declaration for Mental Health Treatment?	Emergency Contacts:		Relationship:	Home phone #:	Work phone #:		
Do you have a Declaration for Mental Health Treatment?							
Living Wills?	Do you have a living will?	□Yes □No		Do you want more information about:			
Treatment?				Living Wills?		□Yes □No	
Treatment?	•			Durable Power of Attorney? □Yes		□Yes □No	
Employee: Literature given? Output Description: Employee Signature:	Treatment?	□Yes □No		Declaration for Mental Health Treatment?		:? □Yes □No	
	Employee: Literature given? □Yes □No Employee Signature:						
	Completed by: Self Mother Father Guardian Other:						

OP 4 - 013.000.01