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:

CCHS utilizes electronic appointment reminders. I understand that I can unsubscribe or opt out by following the instructions in the message.

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 □Asian □Native Hawaiian □Other Pacific Islander
□American Indian/Alaskan Native □More than one race □Unreported/Choose Not to Disclose

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: Living Wills? □Yes □No Durable Power of Attorney? □Yes □No 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: _____