Patient Registration

Allergies_____ Reaction_____

Patient Information

Today's date: _____ DOB: _____ Age: _____ Sex: Male _____ Female _____

Patient's Legal Name: First _____ Last _____ SSN: _____

Patient's Nickname: _____ Maiden Name : _____ Drivers Lic: _____

Other names you have used: _____

Address: _____ Phone: Home _____ Cell _____

City: _____ State: _____ Zip: _____ County: _____ Citizen of US: Yes ____ No ____

Race: (circle one) White Black Native American Asian/Pacific Island Chinese Japanese Hawaiian Filipino Asian Indian Korean Samoan Vietnamese Guam Other: _____

Ethnicity: (circle one) Non-Hispanic Mexican Puerto Rican Cuban Central/South American Other: _____

Are you currently enrolled in WIC (Women, Infant, and Children)? Yes ____No ____ If Yes, how long _____

Marital Status: S M Sep D W N/A (minor) If married, spouse's name: _____

In case of an EMERGENCY please NOTIFY: Name _____
Phone: Home _____ Cell _____ Other _____ Relationship: _____

Insurance Information:

Insurance: (circle one) ☐ Medicaid ☐ None ☐ Private _____

Fill out ONLY if you have <u>Medicaid Insurance</u>

Plan Name: _____ Policy #: _____

Does your insurance cover:

(If No = Underinsured)

Medicaid Spend Down? ◯ Yes ◯ No
Immunizations? ◯ Yes ◯ No
Office Visits? ◯ Yes ◯ No
Womens Health Visits? Yes No

Hospitalization Only? ◯ Yes ◯ No
Labs? ◯ Yes ◯ No

Gross Household Income: per year $_____ per month $_____ **Family Size**: _____

I hereby authorize treatment deemed necessary by the Platte County Health Department Provider. I also authorize the release of my medical records to any Insurance Company with whom I have insurance coverage or to any company to which I have applied for coverage. I understand that I am responsible for ANY amount not covered by insurance if applicable.

Signature: _____ Date: _____

IF PATIENT IS MINOR

Name of legal guardian: _____ Relationship: _____

Name(s) of person with minor: _____

Relationship(s) to minor: _____

Address (if different than patient):_____ City: _____

State: _____ Zip: _____ Phone: Home_____ Cell _____ DOB:_____

Platte County Health Department has offered me a copy of their "Notices of Privacy Practices"

Signature: _____ Date: _____

I hereby grant permission to the Platte County Health Department to obtain laboratory specimens ordered by the provider or by the nursing staff operating under standing orders. **I also understand it is my responsibility to contact Platte County Health Department for all test results if I have not received results within two weeks.** All positive STD test results will be reported to the Missouri Department of Health and if HIV positive or TB positive, I will be offered management services. NO prescriptions (refills or new) will be called in after business hours.

Signature: _____ Date:_____

Nurse/Witness: _____ Date:_____

All services are confidential; however, in the event that we do need to contact you regarding a lab result, may we identify ourselves as the Platte County Health Department? Yes_____ No_____

Please indicate where we CAN call/leave a message with you:

Home: _____ Cell: _____

Work: _____ Other: _____

Please list to whom your medical records may be released to:

Name:_____ Date: _____

Name:_____ Date: _____

1/26/17