



**GREENE COUNTY HEALTH CARE INC
PATIENT REGISTRATION FORM**

Today's Date: _____

Account #: _____

Address	Last Name:	First Name:	Middle Name:
	Title (circle one): Mr. Mrs. Miss Ms.		Generation (circle one): Jr Sr III other _____
	Address:		
	City:	State:	Zip:

Demographics	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated
	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Trans-Man <input type="checkbox"/> Trans-Woman <input type="checkbox"/> Gender Queer <input type="checkbox"/> Other <input type="checkbox"/> Do Not Wish To Disclose	Sexual Orientation: <input type="checkbox"/> Straight <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Unknown <input type="checkbox"/> Other <input type="checkbox"/> Do Not Wish To Disclose
	Social Security Number: - -	Home Phone:
	Date of Birth MM/DD/YYYY: / /	Work Phone:
	Email:	Cell Phone:
	Would you like to receive appointment reminders via Text Message to the cell phone listed above? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Additional	Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
	County of Residence:	Student: <input type="checkbox"/> No <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
	Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Primary Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
	How did you hear about us?: <input type="checkbox"/> TV <input type="checkbox"/> Magazine/Newspaper <input type="checkbox"/> Facebook <input type="checkbox"/> Google <input type="checkbox"/> Yelp <input type="checkbox"/> Other	

**IF YOU DO NOT HAVE MEDICAL OR DENTAL INSURANCE COVERAGE
PLEASE SKIP TO NEXT PAGE**

MEDICAL Insurance	Primary Medical Insurance Carrier:	Policy #:
	Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	Group #:
		Effective Date:
	Secondary Medical Insurance Carrier:	Policy #:
	Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	Group #:
		Effective Date:

DENTAL Insurance	Primary Dental Insurance Carrier:	Policy #:
	Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	Group #:
		Effective Date:
	Secondary Dental Insurance Carrier:	Policy #:
	Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	Group #:
		Effective Date:

Please present copies of all insurance cards to the receptionist.

Patient Profile	Family Size: _____ Total Family Income: _____ per (circle one) Year/Month/Week
	Do you do agricultural work?: <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes: <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> Full Time
	Have you moved in the last 24 months to do agricultural work?: <input type="checkbox"/> No <input type="checkbox"/> Yes
	Is your family currently homeless or displaced?: <input type="checkbox"/> No <input type="checkbox"/> Yes
	Are you a veteran?: <input type="checkbox"/> No <input type="checkbox"/> Yes

Emerg. Contact	Person to Contact in Case of Emergency:	Relationship to You:
	Phone Number: Home: _____ Cell: _____	

Must complete ONLY if patient is a minor child under age 18:

Responsible Party	Last Name:	First Name:	Middle Name:
	Address:		
	City:	State:	Zip:
	Relationship to Patient:		
	Responsible Party Date of Birth:		Responsible Party Social Security Number:
	<p><i>I request and authorize Greene County Health Care to provide health care services to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I acknowledge my responsibility to pay for the care according to fees established.</i></p>		
	Signature of Responsible Party: _____		

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, including NC HIEA NC HealthConnex third parties who have entered into contracts with the NC HIEA, as required, pertaining to treatment rendered to me by Greene County Health Care. Further, I authorize Greene County Health Care to obtain needed information from my other health care providers, employer or insurance company

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my provider and provided by Greene County Health Care, its employees, or representatives. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

NOTICE OF INFORMATION PRACTICES

I acknowledge that I have been given the Notice of Privacy Practices by Greene County Health Care.

ASSIGNMENT OF BENEFITS

I hereby assign all insurance benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Greene County Health Care for health care services rendered to myself and/or my dependents. I understand that I am responsible for deductibles, copays and any amount not covered by insurance.

SLIDING FEE PROGRAM

Greene County Health Care offers a sliding fee scale program based on family size and income. The discount you qualify for is based on federal poverty guidelines and is good for all services received at any Greene County Health Care facility for one year from the date of qualification. However, certain services have a different schedule of discounts based on supplies and equipment involved (for example, dentures, crowns and bridges, IUDs, etc.). If you would like to apply for the sliding fee program please ask the receptionist for an application.

I attest with my signature below that all information provided is true and accurate to the best of my knowledge and that I understand the rights and responsibilities above.

<i>Signature</i>	<i>Date</i>