The Children's Center- Patient Registration Form

A member of Carolina Health Centers Inc.

Patient's Demographic information **PT Acct #__________________**

Patient's Name:____ Birthday:___________________

First Middle Last Month, Day, Year

What is the best contact # to leave messages about appointments, lab results, etc?

Name # Relationship

Patient's Social Security #:______________________________ Sex: **Male Female Other**

Address: ____

City, State Zip County

School/ Daycare:____

Race/Ethnicity/ SOGI/ Language

Race: **Black/ African American Asian American Indian/Pacific Islander White**

Ethnicity: **Hispanic Non-Hispanic Unknown**

Gender Identitty: **Male Female Transgender Female (M to F) Transgender Male (F toM)**

Choose Not to Disclose Non-binary/genderqueer Questioning

Preferred Pronoun: **He/ Him She/Her We/Them**

Sexual Orientation: **Lesbian/Gay Straight Bisexual Something Else**

Don't Know Choose Not To Disclose

Homeless: **Yes No**

Primary Language: **English Spanish Other:____________________**

Are there any impairments or communication barriers that we need to be aware of?

____

Patient's Preferred Primary Care Provider (Please circle one)

Dr. Juan Bonetti Dr. Shelly Brigman Dr. Viardo Polanco Dr. Clarissa Reynoso Dr. Anna Lam

Cheryl Platt, PNP Brandy McGarity, DNP Ashley McDaniel, DNP Angie Welch, PA

Parents/Guardians this section is YOUR information

Parent 1:____

Cell#:______________________________ Work #______________________________________

Email:_____________________________________ Social Security #______________________

Address:____

How do you prefer to be contacted? (please circle one) **CALL TEXT EMAIL**

Parent 2:____

Cell#:______________________________ Work # ______________________________________

Email:_____________________________________ Socail Security #______________________

Address:____

How do you prefer to be contacted? (please circle one) **CALL TEXT EMAIL**

In case of an emergency who should we contact?

____

Name **Number** **Relationship**

Patient's Insurance Information

If your child is covered by Medicaid which plan are they covered by? (cirlce the plan that applies)

Select Health **Molina** **WellCare** **Absolute Total Care** **Healthy Blue**

Insurance ID #____

When did this plan become active coverage for your child?________________________________

If your child has private insurance coverage which plan covers them? (circle or list below)

BCBS **Cigna** **Other:**

Insurance ID or group #____

When did this plan become active coverage?____

Who is the primary card holder:____

Relationship to Patient

Cardholders Date of Birth: Sex: **Male** **Female**

Does your child have a secondary insurance coverage? **YES** **NO**

If yes, what plan is the secondary coverage?_______________________________________

Secondary Coverage ID or group #____

When did the secondary coverage become active?__________________________________

Who is the primary card holder?____

Relationship to Patient

Cardholders Date of Birth:____________________ Sex: **Male** **Female**

Sliding Fee Scale Information: We are required to charge for all services. However, charges may be adjusted according to your income and the number of family members that reside in the home.

☐ **Yes-** I would like an application for the sliding fee scale.

☐ **No-** I do not wish to apply for the sliding fee scale at this time.

How many members reside in the home?____________

Annual Household Income?______________________

Homeless: **YES** **NO**

HIPAA

I understand and comply with Carolina Helath Centers, Inc copy of its Privacy Notice, which explains how my child's health information will be handled in various situations.

I also choose to disclose my child's information to the following individuals:

Name: Contact #:

Name: Contact #:

Name: Contact #:

Signatures of Parent or Patient's who are 16 and older **Date**