How did you hear about Carolina Health Centers?

(Please Check One of the Following)

- FamilyMember, Friend,orCo-Worker
- Newspaper
- Telephone Book
- Health Fair or Other Community Event
- Radio
- Other:

_____

_____

_____

Patient Registration / Demographic Form

LegalName:_____ SSN :_____

Preferred Name:_____ Suffix:_____ Date of Birth:_____

Patient's Mailing & Physical Address:_____

City, State, Zip:_____

Contact Information

Please check your PRIMARY contact number

o Home Phone:_____

o Cell Phone:_____

o Work/Other Phone:_____

Email: _____

Would you like to sign up for MyChart to access your health records and receive important information?

YES_____ NO_____

Sign up via Email_____or Text_____

Emergency Contact

Name:_____

Phone #:_____

Address:_____

City, State,Zip:_____

Relationship to Patient:_____

Please keep in mind this person may be contacted if we can not reach you directly for appointment reminders, lab results, or referral appointments.

HouseHold Survey / Sliding Fee Scale (FPL)

Carolina Health Centers, Inc. is committed to removing barriers that might limit access to receiving quality care in an appropriate primary care medical home. One prevalent barrier is the lack of adequate third party coverage and/or insufficient financial resources to pay for care; therefore, it is the policy of Carolina Health Centers, Inc. to offer discounted care on a sliding fee scale to patients who are eligible based on income and family size. We are required to charge for all services. However, charges may be adjusted according to your income and the number of family members.

What is the estimated total household income annually?:

_____

How many people (including yourself) are supported by the annual income?:

_____

Are you interested in applying for Sliding Fee at this time?

_____Yes I would like an application at this time _____No I do not wish to apply

Signature : _____ Date:_____

Demographics

Please select one box from each of the following sections. The following information is for demographic purposes only and will not affect your care.

Marital Status

- Single ○
- Married ○
- Partnered ○
- Divorced ○
- Separated ○
- Widowed ○

Ethnicity

- Hispanic/Latino ○
- Mexican ○
- Mexican American ○
- Chicano/a ○
- Puerto Rican ○
- Cuban ○
- Another Hispanic ○
- Spanish Origin ○

Race

- White ○
- Black African American ○
- American Indian/Alaskan Native ○
- Asian ○
- Asian Indian ○
- Chinese ○
- Filipino ○
- Japanese ○
- Korean ○
- Vietnam ese ○
- Other Asian ○
- Native Hawaiian ○
- Other Pacific Islander ○
- Guam anian ○
- Chamorro ○
- Sam oan ○

Additional Info

- Veteran ○
- Homeless ○
- Migrant/Seasonal ○

Employment Status

- Full Time ○
- Part Time ○
- Unemployed ○
- Student ○
- Retired ○
- Disabled ○

Preferred Lanuguage

- English ○
- Spanish ○
- French ○
- Other ○
- Translator ○

Gender at Birth

- Male ○
- Fem ale ○

Sexual Orientation

- LesbianorGay ○
- Straight ○
- Bisexual ○
- Something Else ○
- Don't Know ○

Gender Identity

- Male ○
- Female ○
- Transgender Male (female to male) ○
- Transgender Female (male to female) ○
- Other ○
- Chose not to disclose ○

Financial Information

Insurance Information

Guarantor Information (Responsible Party)

Contact Name :_____

Contact Phone #:_____

Mailing Address:_____

City, State, Zip:_____

Relationship to Patient: _____

Subscriber Information (Policyholder of Insurance Coverage)

Policy Holder's Name: _____

Policy Holder's Sex: _____ Male _____ Female

Policy Holder's DOB:_____

Policy Holder's SSN:_____

Relationship to Patient: _____

Primary Coverage Type

- O Medicare - Supplemental YES / NO
- O Medicaid - Supplemental YES / NO
- O United HealthCare
- O Blue Cross
- O TriCare
- O Cigna
- O Other:_____

Member ID: _____

Group #: _____

Copay Amt $:_____

Effective Date: _____

Secondary Coverage YES / NO

Member ID: _____

Signature : _____ Date:_____

HEALTH HISTORY/REVIEW OF SYSTEMS

NAME: _____ AGE:_____DATE:_____ CHART#:_____

Primary Care Provider: _____

Hospitalizations _____

And Surgeries: _____

_____

MedicalProblems: _____

_____

Medications: _____

_____

Allergies: _____

MEDICAL SYMPTOMS: CIRCLE ALL THAT APPLY

General	Use of Tobacco (past or present), Alcohol, Caffeine, or Drugs; Chills; Dizziness; Fainting; Fever; Sweats; History of Cancer; Weight Change; Recurrent Headaches; Anemia; Transfusions; Exposure or Risk of AIDS; Any Exercise? Yes/No Last Tetanus Booster: _____Last Pneumovax: _____
Eyes	Crossed Eyes; Double Vision; Pain; Blurred Vision; Glaucoma; Red Eyes
Ears	Earache; Discharge; Loss of Hearing; Ringing in Ears
Nose/Throat	Nosebleeds; Thyroid Problems; Sinus Trouble; Hay Fever; Hoarseness; Teeth or Gum Problems
Cardiovascular	Chest Pain; High Blood Pressure; Irregular Heart Beat; Poor Circulation; Murmur; Heart Attacks; Heart Disease; Shortness of Breath; High Cholesterol
Respiratory	Chronic Cough; Asthma; Emphysema; Coughing up Blood; Pneumonia; Wheezing; Night Sweats
Gastrointestinal	Poor Appetite; Bowel Changes; Constipation; Diarrhea; Nausea; Ulcers; Rectal Bleeding; Liver Disease; Jaundice; Hepatitis; Gallbladder Disease; Hemorrhoids; Blood in Stools; Dark or Black Stools
Genitourinary	Blood in Urine; Painful Urination; Difficult Urination; Prostate Problems; Kidney Stones; Venereal Disease; Sexual Difficulties
Musculoskeletal	Arthritis; Gout; Fractures; Chronic Back Pain; Injuries
Neurologic	Confusion; Head Injury; Numbness; Seizures; Fainting; Stroke; Dizziness
Psychiatric	Anxiety; Depression; Drug Addiction; Suicide Attempt; Sleeping Difficulties; Marital Problems
Endocrine	Diabetes; Lethargy or Fatigue; Heat or Cold Intolerance; Thyroid Disease
Skin Diseases	Dry Skin; Skin Cancers; Sores that Don't Heal; Changing Moles
Gynecological (females only)	Last Pap Smear:_____Last Mammogram;_____# of Pregnancies:_____# of Births:_____ Birth Control Method: None – Pill – Condoms – Diaphragm – Rhythm – IUD – Shots – Tubal – Vasectomy-Other Irregular of Painful Periods; Bleeding Between Periods or after Sex
Family History	Circle Illnesses that Parents or Siblings Have or Have Had: Diabetes; Heart Disease; Hypertension or High Blood Pressure; Cancer; Alcohol Abuse; Strokes; Asthma; Depression; Tuberculosis, Glaucoma

Other Comments

_____ _____

Provider Signature DATE

Carolina Health Centers Inc.

313 Main St. Suite B – Greenwood, SC 29646
Phone: (864) 388-0301 Fax: (864) 388-0648

TWO-WAY CONSENT FOR RELEASE OF MEDICAL INFORMATION/RECORDS:

I authorize ongoing communication and all my records (including office notes, x-ray, and pathology reports, laboratory reports, hospital reports and all other records) to be shared between Carolina Health Centers, Inc. and the below-named facility:

Facility Name: _____
Provider's Name: _____
Address: _____
_____
Phone #: _____ Fax #: _____

Additionally, I authorize the above-named facility to communicate with and share records with Carolina Health Centers, Inc.

I am aware of and specifically waive any privilege regarding the following information which may or may not be contained in these records:

1. *Communications between patient and psychiatrist and/or psychologist.*
2. *Medical information concerning alcohol and drug dependency or treatment.*
3. *Medical information concerning HIV infection status or AIDS.*

I authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse or dependency or treatment and HIV/AIDS confidential information that is needed for any utilization review or quality assurance activities. The assignment will remain in effect until revoked by me in writing addressed to Carolina Health Centers, Inc or for one year whichever comes first.

Patient Name: _____ SS#: _____
Personal Representative: _____ Relationship: _____
Address: _____ DOB: _____
_____ Phone #: _____

Signature: _____ Date: _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the disclosure of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Revised 3/2021

Return By: _____

Sliding Fee Application

Name	Relation to you	Date of Birth	Address

You must verify your income yearly. We accept yearly tax return, W-2, paycheck stubs, Social Security benefits or other forms of income you receive will be sufficient proof. Your annual income and family size will be used to calculate your discount. **NO BANK STATEMENTS**

Source	Self	Other
Gross wages, salaries, tips etc. Income from business or self-		
employment		
Unemployment compensation, workers compensation, SSI, Veterans Payments, Pension or retirement income		
Other (Specify)		
Other (Specify)		
Other (Specify)		

Patient Signature: _____ Date: _____

Office UseOnly:

Sliding Fee Level: _____ Total Annual Income: _____
Date Approved: _____ Expiration Date: _____
Signature of Employee: _____
Notes:_____
_____

Statement of Income (Sliding Fee Application)

I currently do not have any income. I am (Check appropriate box):

___ Unemployed
___ Stay at home parent or guardian
___ Retired without a pension
___ Student
___ Other _____

Signature: _____ Date: _____

Carolina Health Centers Inc.

¿Como se entero de Carolina Health Centers?

(Porfavor escoja uno de los sigentes)

- Miembro de familia, Amigo/a, o companero de trabajo
- Periodico
- Libro telefonico
- Feria de salud o otro evento de la comunidad
- Radio
- Otro: _____

_____

_____

Registro de Paciente

Nombre Legal: _____ Fechade Nacimiento: _____

Nombre de preferencia: _____ Sufjo:____ Numero Social: _____

Direccion de Paciente: _____

Cuidad, Estado y Codigo Postal: _____

Informacion de Paciente

Telefono Celular: _____

Telefono de Trabajo: _____

Correo Electronico: _____

Le gustaria enlistarse a MyChart para obtener aceso a su expediente medico y recibir informacion importante?

Si __ No __

Correo Electronico ___ Mensaje de texto ___

Contacto de Emergencia

Nombre:_____

Telefono: _____

Direccion: _____

Relacion al Paciente: _____

Esta persona sera contactada si no podemos comunicarnos directamente con usted para recodarle de citas,resultados de laboratorio o ordenes medicas.

Persona Responsible del Paciente

Nombre: _____

Numero de Telefono: _____

Direccion: _____

Cuidad, Estado, Codigo Postal: _____

Información del Suscriptor

Fecha de expiracion: _____

Poseedor de Tarjeta es:__Masculino _ Femenino

Fecha de Nacimiento: _____

Copago: _____

Informacion de Seguro Medico

- ☐ Medicare
- ☐ Medicaid
- ☐ United Healthcare
- ☐ Blue Cross Blue Shield
- ☐ Blue Choice
- ☐ Cigna
- ☐ Other

Id de Miembro: _____

Numero de Grupo: _____

Fecha vigente de aseguranza: _____

Copago: _____

Cobertura Secundaria:SI/ NO

Id de Miembro:_____

Firma de Paciente: _____ Fecha: _____

Escala Variable/ Informacion de aseguranza

Carolina Health Centers, Inc. se compromete aeliminar las barreras que podrían limitar el acceso a recibir atención de calidad en un hogar médico de atención primaria adecuado. Un obstáculo prevalente es la falta de cobertura adecuada y/o recursos financieros insuficientes para pagar; por lo tanto, es política de Carolina Health Centers, Inc. ofrecer atención con descuento en una escala variable de tarifas a los pacientes que son elegibles según los ingresos y el tamaño de la familia. Estamos obligados a cobrar por todos los servicios. Sin embargo, los cargos pueden ajustarse de acuerdo con sus ingresos y el número de miembros de la familia.

___ Si me gustaría obtener una aplicación ___ No en este momento

Demografico de paciente

Por favorseleccione una opcion por seccion. La siguiente informacion es solamente para el proposito demografico y no le afecta en su cuidado medico.

Situacion Laboral

- Tiempo Completo ☐
- Medio Tiempo ☐
- Desempleado ☐
- Estudiante ☐

Estado Civil

- ~~Soltero/a~~ ☐
- Casado/a ☐
- Union Libre ☐
- Separado/a ☐
- Viudo/a ☐

Orientacion Sexual

- Heterosexual ☐
- Lesbiana/ Homosexual ☐
- Bisexual ☐
- Distinto/ Diferente ☐
- No se ☐
- Opto por no Revelar ☐

Informacion adicional

- Veterano ☐
- Indigente ☐
- Trabajador Migrante ☐
- Trabajador de Temporada ☐

Idioma Preferido

- Ingles ☐
- Espanol ☐
- Frances ☐
- Otro ☐
- Traductor ☐

Raza

- ~~Afro~~americano ☐
- Asicatico ☐
- Nativo Americano/Alaska ☐
- Nativo de Hawai/Islas del Pacifico ☐
- Blanco ☐
- Asiatico Indio ☐
- Chino ☐
- Filipino ☐
- Japones ☐
- ☐
- Samoano ☐
- Chamorro ☐
- Koreano ☐
- Vietnamita ☐
- Otro Asiatico ☐
- Guameno ☐

Origen Etnico

- Hispano Latino/ Origen Espanol ☐
- No- Hispano/ Latino ☐
- Mexicano/a ☐
- Mexicano Americano ☐
- Chicano/a ☐
- Puetro Ricano ☐
- Cubano ☐
- Otra Hispanidad ☐
- Origen Espanol ☐

Identidad de Genero

- Masculino ☐
- Femenino ☐
- Transgenero Femenino a Masculino ☐
- Transgenero Masculino / Femenino ☐
- Otro/ Opto por no revelar ☐

Genero A Nacer

- Masculino ☐
- Femenino ☐

HISTORIAL DE SALUD # de Exediente: _____

NOMBRE y APELLIDO: _____ EDAD: _____ FECHA: _____

Hospitalizaciones y Cirugías: _____

_____

Problemas Médicos: _____

_____

¿Toma Medicamentos?: _____

_____

Alergias que usted tiene a la medicina: _____

Síntomas Médicos: Marque todoslos síntomas de que padece

General	Uso de: Tabaco (en el pasado o presente); alcohol,cafeína o drogas' escalofrios;mareo; desmayo; fiebre; sudores; histori de cancer; un cambio de peso; Dolores decabeza recurrentes; anemia; transfusion de sangre; expuesto al o riesgo del SIDA; ¿Cuándo fue su ultima vacunacontra tétano? _____ ¿contra pulomia? _____ ¿Hace usted ejercicios? Si/No
Ojos	Ojos cruzados; vision doble; dolor de ojo; vision borrosa; glaucoma; ojos enrojecidos
Oídos	Dolor de oído; descarga del oído; pérdida de oído; zumbido en los oídos
Nariz/garganta	Sangramiento de la nariz; problemas con la tiroides; sinusitis; fiebre de heno; ronquera; problemas con los dientes o las encías
Cardiovascular	Dolor en el pecho; alta presión de la sangre; ritmo cardiac irregular; circulación inadecuada; murmullos del corazón; ataque al corazón; enfermedad cardiac; falta de aire; coleserol alto
Respiratorio	Tos crónica; asma; enfisema; expectoración de sangre; pulmonía; respiración sibilante; sudores noctumos
Gastrointestinal	Falta de apetito; cambios entestinales; estreñimiento; diarrhea; nausea; úlceras; sangramiento del recto; enfermedades del hígado; ictericia; hepatitis; enfermedad de la vesícala biliar; hemorroides; sangre en el excrement; excrement muy oscuro o negreo
Genitourinario	Sangre en las orina; dolor y/o ardor al orinar; dificultad para orinar; problemas con la prostate; calculus renales; enfermedad venérea; dificultades sexuales
Musculoesqueleto	Artritis; gota; fracturas; dolor de espalda crónico; heridas
Neurológico	Confusión; lesions en las cabeza; entumecimiento; convulsions; desmayo; derrame cerebral; mareo o vértigo
Psiquiátrico	Ansiedad; depression; adicción a drogas; intent de suicidio; dificultad para dormer; problemas en el matrimonio
Endocrina	Diabetes; letargo o cánsancio; intolerancia al calor o frio; enfermedad de la tiroides
Dermatosis	Piel seca; cancer de piel; ilagasque no se sanan; lunares que se cambian de aparición
Ginecológico (sólo mujeres)	Fecha de su ultimo papanicolao: _____ ultimo mamograma: _____ # de embarazos: _____ # de nacimintos: _____; reglas irregulars o dolorosas; sangramiento entre reglas o después de tener relaciones. Método anticonceptivo que usa: ninguno – la pastille anticonceptiva – condones – diafragma – ritmo – dispositivo intrauterine – inyecciones – ligadura de las trompas – vasectromía – otro
Historia Familiar	Favor de marcar las enfermedases que sus familiars tienon o han tendio: diabetes; enfermedades cardíacas; hypertension o alta presión de sangre; cáncer; abuso de alcohol; ; derrame cerebral; asma; depression; tuberculosis; glaucoma

Otro síntomas y/o comentarios: _____

_____

_____ _____

Firma de Abastecedor Fecha

Fecha de Devolucion: _____

Solicitud de Tarifa Variable

Nombre	Relacion con usted	Fecha de Nacimiento	Direccion

Debe verificar sus ingresos anualmente. Aceptamos la declaracion anual de impuestos, W-2, talons de cheques, beneficios del Seguro Social, o otras formas de ingreso que reciba seran pruebas suficiente. El ingreso anual y tamano de familia se usara para calcular su descuento. **NO TOMAMOS DECLARACIONES BANCARIAS**

Fuente	Propio	Otro
Salario total, salarios, propinas etc.		
Ingresos de negocios o trabajo por cuenta propia		
Compensacionpor desempleo, compensacióndetrabajadores, SSI, pagos de veteranos, pensión o ingresos de jubilacion		
Otra forma (Especificar)		
Otra forma (Especificar)		

Firma del paciente: _____ Fecha: _____

Solo para usodeoficina:

Nivel de tarifa: _____ Ingreso anual total: _____
Fecha de aprobacion: _____ Fecha de caducidad: _____
Firma de empleado: _____
Notas:_____
_____

Declaracion de Ingresos (Solicitud de Escala Variable)

Actualmentenotengo ningun Ingreso. Yo me encuentro: (Por Favor marque la respuesta que corespondaausted):

___Desempleado

___Ama /o De casa o Tutor

Jubilado sin una Pension

___Estudiante

___Otro _____

Firma_____Fecha_____

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Revised 3/2021