



**How Did You Hear About Carolina Health Centers?**

**(Please Check One of the Following)**

- Family Member, Friend, or Co-Worker
- Newspaper
- Telephone Book
- Health Fair or Other Community Event
- Radio
- Other:

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# Patient Registration / Demographic Form

Legal Name: \_\_\_\_\_ SSN : \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Suffix: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient's Mailing & Physical Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Contact Information

*Please check your PRIMARY contact number*

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work/Other Phone: \_\_\_\_\_

Email: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

*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 \_\_\_\_\_

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

### 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

#### Additional Info

- Veteran
- Homeless
- Migrant/Seasonal

#### Gender at Birth

- Male
- Female

#### Employment Status

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

#### Sexual Orientation

- Lesbian or Gay
- Straight
- Bisexual
- Something Else
- Don't Know

#### Ethnicity

- Hispanic/Latino
- Non-Hispanic/Latino

#### Race

- American Indian/Alaskan Native
- Asian
- Black African American
- Native Hawaiian/Pacific Islander
- White
- Unknown / Choose not to disclose

#### Preferred Lanuguage

- English
- Spanish
- French
- Other
- Translator

#### Gender Identity

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



# Patient Financial Information

## Financial Information

### 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

## Insurance Information

### Guarantor Information (Responsible Party)

### Subscriber Information (Policyholder of Insurance Coverage)

Contact Name : \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Contact Phone #: \_\_\_\_\_

Policy Holder's Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female

Mailing Address: \_\_\_\_\_

Policy Holder's DOB: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Policy Holder's SSN: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

### Primary Coverage Type

- Medicare - Supplemental YES / NO
- Medicaid - Supplemental YES / NO
- United HealthCare
- Blue Cross
- TriCare
- Cigna
- 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: \_\_\_\_\_

\_\_\_\_\_

Medical Problems: \_\_\_\_\_

\_\_\_\_\_

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 or 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



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.*

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*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.





**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** \_\_\_\_\_