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. David Bowen Ryan Brown, DNP

Cheryl Platt, PNP Brandy McGarity, DNP Ashley McDaniel, DNP Amanda Walton, PA

Parents/Guardians this section is YOUR information

Parent 1:_____Birthday:_____

Cell#:_____ Work #_____

Email:_____ Social Security #_____

Address:_____

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

Parent 2:_____Birthday:_____

Cell#:_____ Work # _____

Email:_____ Social 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**