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

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

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

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
- ☐ Female

Sexual Orientation

- ☐ Lesbian or Gay
- ☐ 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

Race

- ☐ White
- ☐ Black African American
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Guamanian
- ☐ Chamorro
- ☐ Samoan

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

- ☐ 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 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

313 Main St. Suite A – Greenwood, SC 29646
Phone: (864) 229-4446 Fax: (864) 229-8037

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 Use Only:

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: _____