CONFIDENTIAL REGISTRATION AND CONSENT FORM

Patient Name: ____
Last First Middle

c/o: ______________________________________ Relationship to Patient: _____________________

Street Address: ____

City: ____________________________ **State:** _____________________ **Zip**: _________________

Home Phone: _________________________ **Work Phone**: _________________________

Male or Female (Please circle) **County of Residence**: _______________

Birthdate: (Month)________ (Day)_____ (Year)________ **Social Security Number**: _____ - _____ - _____

Patient Marital Status (Circle one): Minor Single Married Divorced Widowed Other

Is Patient (Circle): Unemployed / Employed Full Time/ Employed Part Time / Full Time Student/ Other: ____

Name of Employer or School: ______________________________________

Billing Address (if bill is to be sent to an address other than the above address):
Name: _________________________ Relationship to Patient: ____________________

Street Address: ____

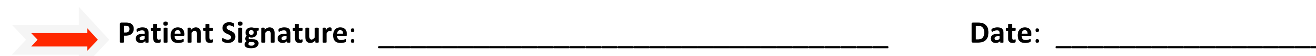
City: ____________________________ State: _____________________ Zip: ________

Emergency Contact Name: ______________________________ **Relationship to Patient**: ____________
Last First MI

Day Phone: (_____)__________ Evening Phone: (_____)__________ Cell Phone: (_____)__________

I give my **permission to release medical information** to the following individuals listed below. (Could include spouse, parent, grandparent, child and/or sibling, etc.) You do **not** have to select anyone.
1. ________________________________ 3. ___________________________________
2. ________________________________ 4. ___________________________________

I hereby **give consent for treatment** to the health care providers of the Clay-Battelle Health Services Association.


Patient Signature: ______________________________ **Date**: ________________

Please complete other side……

CONFIDENTIAL REGISTRATION AND CONSENT FORM

To assist us in your determining eligibility for other programs, and providing statistical information to our federal and state grant agencies, please provide us with the following information:

Number in household: _____ Household Income: ________ Monthly/Annually (Circle one)

Ethnic Information (Circle one): White, not Hispanic Black, not Hispanic Hispanic
Asian or Pacific Islander American Indian Other

Have you ever been discharged from the military? Yes No

PRIMARY INSURANCE

Insurance Name: ____

Insurance Address: ____

Group Name: ____

Policy Holder Name: _______________________________________

Policy Holder Date of Birth: Month_____ Day_____Year_____

Is this Insurance through your Employer? Yes No

Employer Name: ____________________________________ Employer Phone No.: (   )__________

SECONDARY INSURANCE

Insurance Name: ____

Insurance Address: ____

Group Name: ____

Policy Holder Name: _______________________________________

Policy Holder Date of Birth: Month_____ Day_____Year_____

Is this Insurance through your Employer? Yes No

Employer Name: ____________________________________ Employer Phone No.: (   )__________

I hereby authorize payment directly to the offices of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of treatment.

Patient Signature: ________________________________ **Date**: ________________