CHARLES HENDERSON CHILD HEALTH CENTER
PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last First Middle Nickname

Birth date: Month _____ Day_____ Year_____ **Age** **Gender: Male ☐ Female ☐**

Address County

City State Zip code +4

Best Phone Other phone

May we leave you a message regarding upcoming appointments? Yes ☐ No☐

Preferred language email address

Race: You may check more than one.
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic, Latino or Spanish Origin
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Other: _____

Emergency contact _____
(**not living with you**)

Relationship _____
(**to the patient)**

Emergency phone_____

PARENT INFORMATION

Mother/Legal guardian name	Father's name
Employer	Employer
Employer's Phone	Employer's Phone

Parent's Marital Status: ☐Single, ☐Married, ☐Divorced – If divorced who has custody of child? _____ ☐Widowed

INSURANCE INFORMATION

Primary Insurance Name	Secondary Insurance Name
Policy Holder Name	Policy Holder Name
Policy Holder's DOB	Policy Holder's DOB
Contract #	Contract#
Group #	Group#
Group Name	Group Name

AUTHORIZATION FOR MEDICAL, DENTAL AND/OR DIAGNOSTIC TREATMENT: I, the undersigned, a patient (or the legal guardian of a patient) hereby authorize the Charles Henderson Child Health Center, its doctors, dentists or designated assistants to administer such treatment as is necessary, and to perform medical, dental and diagnostic treatment or tests and such additional procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained. _____ **INITIAL**

****

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment of insurance benefits to the Charles Henderson Child Health Center and/or physician under the terms of my policy. I hereby authorize the Center and/or physician to release any information acquired in the course of my examination or treatment so that my insurance benefits may be promptly filed. _____**INITIAL**

****

NON-COVERED SERVICES WAIVER: As our patient, we want to provide you the best care possible. There may be certain routine services that we feel are necessary for the maintenance of good health that are not covered by your Blue Cross and Blue Shield of Alabama health benefits contract. You are expected to pay for those services in full. For example, we may order x-rays, lab tests, or vaccines that may not be covered. We will only order tests that we feel are necessary for your treatment and care. _____**INITIAL**

****

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: By signing his document, I acknowledge that I have received a copy of Charles Henderson Child Health Center's Notice of Privacy Practices. _____**INITIAL**

****

By signing below, I authorize and acknowledge all initialed items above.

_____ _____ _____

Patient/Guardian Signature **Date** **Relationship to Patient**

FINANCIAL ASSISTANCE: Children (under age 19) may be eligible for financial assistance. They shall be identified by completion of a financial interview. You must give proof of your income in the form of tax returns, check stubs, and other such documentation. Patients not providing such documentation will be required to pay total charges at time of service.

_____ I would like to apply for financial assistance. _____

Signature