Today's Date:_____
Account #:_____

GREENE COUNTY HEALTH CARE INC
PATIENT REGISTRATION FORM

Address

Last Name:	**First Name:**	**Middle Name:**
Title (*circle one*): Mr. Mrs. Miss Ms.	**Generation** (*circle one*): Jr Sr III other _____	
Address:		
City:	**State:**	**Zip:**

Demographics

Gender: ☐ Male ☐ Female	**Marital Status**: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated
Gender Identity: ☐ Male ☐ Female ☐ Trans-Man ☐ Trans-Woman ☐ Gender Queer ☐ Other ☐ Do Not Wish To Disclose	**Sexual Orientation:** ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Unknown ☐ Other ☐ Do Not Wish To Disclose
Social Security Number: - -	**Home Phone:**
Date of Birth MM/DD/YYYY: / /	**Work Phone:**
Email:	**Cell Phone:**
Would you like to receive appointment reminders via Text Message to the cell phone listed above? ☐ Yes ☐ No	

Additional

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Native Hawaiian ☐ Other	**Ethnicity**: ☐ Hispanic ☐ Non-Hispanic
County of Residence:	**Student:** ☐ No ☐ Full Time ☐ Part Time
Primary Language: ☐ English ☐ Spanish ☐ Other: _____	**Primary Phone:** ☐ Home ☐ Cell ☐ Work
How did you hear about us?: ☐ TV ☐ Magazine/Newspaper ☐ Facebook ☐ Google ☐ Yelp ☐ Other	

Revised 12/18

Account #:_____

IF YOU <u>DO NOT</u> HAVE MEDICAL OR DENTAL INSURANCE COVERAGE

PLEASE SKIP TO NEXT PAGE

MEDICAL Insurance

Primary Medical Insurance Carrier:	**Policy #:**
Policyholder: ☐ Self ☐ Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	**Group #:** **Effective Date:**
Secondary Medical Insurance Carrier:	**Policy #:**
Policyholder: ☐ Self ☐ Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	**Group #:** **Effective Date:**

DENTAL Insurance

Primary Dental Insurance Carrier:	**Policy #:**
Policyholder: ☐ Self ☐ Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	**Group #:** **Effective Date:**
Secondary Dental Insurance Carrier:	**Policy #:**
Policyholder: ☐ Self ☐ Other If Other: Policyholder Name: _____ Relationship to Patient: _____ Policyholder Date of Birth: _____	**Group #:** **Effective Date:**

Please present copies of all insurance cards to the receptionist.

Account #:_____

Patient Profile

Family Size: _____ Total Family Income: _____ per (*circle one*) Year/Month/Week

Do you do agricultural work?: ☐ No ☐ Yes If Yes: ☐ Migrant ☐ Seasonal ☐ Full Time

Have you moved in the last 24 months to do agricultural work?: ☐ No ☐ Yes

Is your family currently homeless or displaced?: ☐ No ☐ Yes

Are you a veteran?: ☐ No ☐ Yes

Emerg. Contact

Person to Contact in Case of Emergency:	**Relationship to You:**

Phone Number:

Home:_____ Cell: _____

Must complete ONLY if patient is a minor child under age 18:

Responsible Party

Last Name:	***First Name:***	***Middle Name:***
Address:		
City:	***State:***	***Zip:***
Relationship to Patient:		
Responsible Party Date of Birth:	***Responsible Party Social Security Number:***	

I request and authorize Greene County Health Care to provide health care services to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I acknowledge my responsibility to pay for the care according to fees established.

Signature of Responsible Party: _____

Account #:_____

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, including NC HIEA NC HealthConnex third parties who have entered into contracts with the NC HIEA, as required, pertaining to treatment rendered to me by Greene County Health Care. Further, I authorize Greene County Health Care to obtain needed information from my other health care providers, employer or insurance company

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my provider and provided by Greene County Health Care, its employees, or representatives. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

NOTICE OF INFORMATION PRACTICES

I acknowledge that I have been given the Notice of Privacy Practices by Greene County Health Care.

ASSIGNMENT OF BENEFITS

I hereby assign all insurance benefits to which I am entitled. I hereby authorize and direct my insurance carriers(s), including Medicare, private insurance and any other health/medical plan, to issue payment directly to Greene County Health Care for health care services rendered to myself and/or my dependents. I understand that I am responsible for deductibles, copays and any amount not covered by insurance.

SLIDING FEE PROGRAM

Greene County Health Care offers a sliding fee scale program based on family size and income. The discount you qualify for is based on federal poverty guidelines and is good for all services received at any Greene County Health Care facility for one year from the date of qualification. However, certain services have a different schedule of discounts based on supplies and equipment involved (for example, dentures, crowns and bridges, IUDs, etc.). If you would like to apply for the sliding fee program please ask the receptionist for an application.

I attest with my signature below that all information provided is true and accurate to the best of my knowledge and that I understand the rights and responsibilities above.	
Signature	***Date***