CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT
PATIENT REGISTRATION INFORMATION

Today's Date: ______________________

Patient's Name:	(last) (first) (middle)		
Other Last Name:		**Maiden Name:**	
Date of Birth:		**Student:**	☐ No ☐ Full-time ☐ Part-time
Street Address:		**PO Box:**	
City/State/ZIP:		**County:**	
Phone:	(home) (work) (cell)		
Social Security #:		**May We Contact You?**	☐ Yes ☐ No

Race: Check One or More	Sex:	Marital Status:	Ethnicity Is Hispanic?	Years of Education	Primary Language:	National Origin	
☐ White ☐ Asian ☐ Black or African/American ☐ Native American ☐ Pacific Islander	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Yes ☐ No	(Specify Number)	☐ English ☐ Spanish ☐ Other	**Country:**	
						Entry Date to U.S.:	

ADDITIONAL FAMILY MEMBER TO BE SEEN TODAY

Patient's Name:	(last) (first) (middle)			
Date of Birth:		**Race:**	☐White ☐ Asian ☐ Black ☐ Native Amer. ☐ Pacific Islander	
Social Security Number:		**Sex:**	**Hispanic:** ☐ Yes ☐ No	**Primary Language:**

RESPONSIBLE PARTY and EMERGENCY CONTACT INFORMATION

Responsible Party:	(last) (first) (middle)				
Social Security Number:		**Relationship:**			
Emergency Contact Name:		**Relationship:**		**Phone #:**	

INSURANCE POLICYHOLDER

Policyholder:	(last) (first) (middle)		
Social Security Number:		**Relationship:**	
Date of Birth:		**Employer:**	

FINANCIAL INFORMATION

Family Size and Income Before Taxes (Used to calculate sliding scale charges.)		**Medical Insurance including TennCare**			
Number of People in Household:		**Do you have health insurance?**	☐ Yes ☐ No		
HOUSEHOLD Employment Income:		**Does your insurance cover vaccines?**	☐ Yes ☐ No		
Child Support/Alimony:		**Primary Insurance:**		**Secondary Insurance:**	
Unemployment Compensation:		**ID Number:**		**ID Number:**	
Supplemental Security Income (SSI):		**Effective Date:**		**Effective Date:**	
TANF / Food Stamps:	☐Yes ☐ No	**Signature of Responsible Party**			
TOTAL:		______________________________			