**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<br>☐ Asian<br>☐ Black/African American<br>☐ Native American<br>☐ Pacific Islander | ☐ Male<br>☐ Female | ☐ Single<br>☐ Married<br>☐ Divorced<br>☐ Separated<br>☐ Widowed | ☐ Yes<br>☐ No | (Specify Number)<br>_____ | ☐ English<br>☐ Spanish<br>☐ Other | **Country:** | |
| | | | | | | **Entry Date to U.S.:** | |

## RESPONSIBLE PARTY

| | | | | | |
|---|---|---|---|---|---|
| **Responsible Party:** | *(last)* *(first)* *(middle)* | | | | |
| **Date of Birth:** | | **Social Security Number:** | | **Relationship:** | |

## EMERGENCY CONTACT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| **Emergency Contact Name:** | | **Relationship:** | | **Phone #:** | |

## INSURANCE POLICYHOLDER (If other than patient)

| | | | |
|---|---|---|---|
| **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:** | | _____ | | | |