

**CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT  
PATIENT REGISTRATION INFORMATION**

Today's Date: \_\_\_\_\_

<b>Patient's Name:</b>	(last)	(first)	(middle)
<b>Other Last Name:</b>			<b>Maiden Name:</b>
<b>Date of Birth:</b>			<b>Student:</b> <input type="checkbox"/> No <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
<b>Street Address:</b>			<b>PO Box:</b>
<b>City/State/ZIP:</b>			
<b>Phone:</b>	(home)	(work)	Cell:
<b>Social Security #:</b>			<b>May We Contact You?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Race: Check One or More</b>	<b>Sex:</b>	<b>Marital Status:</b>	<b>Ethnicity Is Hispanic?</b>
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black or African/American <input type="checkbox"/> Native American <input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<b>Years of Education</b> (Specify Number)
			<b>Primary Language:</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other
			<b>National Origin</b> <b>Country:</b>
			<b>Entry Date to U.S.:</b>

**ADDITIONAL FAMILY MEMBERS TO BE SEEN TODAY**

<b>Patient's Name:</b>	(last)	(first)	(middle)
<b>Date of Birth:</b>			<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Amer. <input type="checkbox"/> Pacific Islander
<b>Social Security Number:</b>		<b>Sex:</b>	<b>Hispanic:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Primary Language:</b>
<b>Patient's Name:</b>	(last)	(first)	(middle)
<b>Date of Birth:</b>			<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Native Amer. <input type="checkbox"/> Pacific Islander
<b>Social Security Number:</b>		<b>Sex:</b>	<b>Hispanic:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Primary Language:</b>

**RESPONSIBLE PARTY INFORMATION**

<b>Responsible Party Name:</b>	(last)	(first)	(middle)
<b>Relationship:</b>			<b>Social Security Number:</b>

**FINANCIAL INFORMATION**

(We use this information to determine how much you owe for today's services, otherwise you will have to pay our full charges.)

Family Size and Income Before Taxes		TennCare or Medical Insurance	
<b>Number of People in Household:</b>		<b>Company Name:</b>	
<b>HOUSEHOLD Employment Income:</b>		<b>ID Number:</b>	
<b>Child Support/Alimony:</b>		<b>Effective Date:</b>	
<b>Unemployment Compensation:</b>		<b>Signature of Responsible Party</b>  _____	
<b>Retirement:</b>			
<b>Supplemental Security Income (SSI):</b>			
<b>TN Assistance for Needy Families (TANF):</b>			
<b>TOTAL:</b>			