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
Email Address:			

Race: Check One or More	Sex:	Marital Status	Ethnicity Is Hispanic?	Years of Education	Primary Language:	National Origin
☐ White ☐ Asian ☐ Black/African American ☐ American Indian/Alaska Native ☐ Pacific Islander ☐ Native Hawaiian ☐ Declined to Specify ☐ Other	☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	☐ Yes ☐ No	(Specify Number) _____	☐ English ☐ Spanish ☐ 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:					

CHATTANOOGA-HAMILTON COUNTY HEALTH DEPARTMENT
INFORMACION DE REGISTRO DEL PACIENTE

Fecha de hoy: ____________________

OTRO MIEMBRO ADICIONAL DE LA FAMILIA QUE TIENE CITA EL DÍA DE HOY

Nombre del paciente :	*(apellidos)*	*(primer nombre)*	*(segundo nombre)*	
Fecha de nacimiento :		**Raza:** □ Blanco/a □ Asiático/a □ Afro-Americano/a □ Indio-Americano/a □ Islas del Pacífico		
Número de Seguro Social :		**Sexo:**	**Hispano:** □ Sí □ No	**Lengua materna:**

Seguro médico incluyendo a TennCare			
¿Tiene usted seguro médico privado?		□ Sí □ No	
Si su respuesta es "sí", ¿pagan ellos por las vacunas?		□ Sí □ No	
Seguro primario:		**Seguro secundario:**	
Número de identificación del seguro:		**Número de identificación del seguro:**	
Fecha de efectividad:		**Fecha de efectividad:**	

OTRO MIEMBRO ADICIONAL DE LA FAMILIA QUE TIENE CITA EL DÍA DE HOY

Nombre del paciente :	*(apellidos)*	*(primer nombre)*	*(segundo nombre)*	
Fecha de nacimiento :		**Raza:** □ Blanco/a □ Asiático/a □ Afro-Americano/a □ Indio-Americano/a □ Islas del Pacífico		
Número de Seguro Social :		**Sexo:**	**Hispano:** □ Sí □ No	**Lengua materna:**

Seguro médico incluyendo a TennCare			
¿Tiene usted seguro médico privado?		□ Sí □ No	
Si su respuesta es "sí", ¿pagan ellos por las vacunas?		□ Sí □ No	
Seguro primario:		**Seguro secundario:**	
Número de identificación del seguro:		**Número de identificación del seguro:**	
Fecha de efectividad:		**Fecha de efectividad:**	

OTRO MIEMBRO ADICIONAL DE LA FAMILIA QUE TIENE CITA EL DÍA DE HOY

Nombre del paciente :	*(apellidos)*	*(primer nombre)*	*(segundo nombre)*	
Fecha de nacimiento :		**Raza:** □ Blanco/a □ Asiático/a □ Afro-Americano/a □ Indio-Americano/a □ Islas del Pacífico		
Número de Seguro Social :		**Sexo:**	**Hispano:** □ Sí □ No	**Lengua materna:**

Seguro médico incluyendo a TennCare			
¿Tiene usted seguro médico privado?		□ Sí □ No	
Si su respuesta es "sí", ¿pagan ellos por las vacunas?		□ Sí □ No	
Seguro primario:		**Seguro secundario:**	
Número de identificación del seguro:		**Número de identificación del seguro:**	
Fecha de efectividad:		**Fecha de efectividad:**	

Nombre de la persona responsable	**Firma de la persona responsable**
______________________________	______________________________

HAMILTON COUNTY HEALTH DEPARTMENT
CHATTANOOGA, TN

Place PAL Label Here

DENTAL MEDICAL HISTORY
HISTORIA MÉDICA DENTAL

Today's Date/Fecha de hoy: _____

Please answer each question / Por favor conteste todas las preguntas:

1. **Does the patient now have, or ever had, any of the following medical conditions?**
   ¿Presenta el paciente, o ha tenido anteriormente, alguna de las siguientes condiciones médicas?

Medical Condition / Condición Médica	YES/SI	NO		YES/SI	NO
Heart Disease Enfermedad del corazón			**High Blood Pressure** Presión arterial alta		
Rheumatic Fever Fiebre reumática			**Tuberculosis (TB)** Tuberculosis		
Heart Murmur Murmullo o soplo cardíaco			**Allergies** Alergias		
Heart Attack Ataque cardíaco / Infarto del corazón			**Allergic to Penicillin** Alérgico a la penicilina		
Pace Maker Marcapaso			**Any Drug Reactions** Reacciones a medicamentos		
Stroke Embolia cerebral / Parálisis			**Under the care of a physician?** ¿Se encuentra actualmente bajo cuidado médico?		
Asthma Asma			**Taking regular medicines?** ¿Toma medicinas diariamente?		
Epilepsy/Seizures Epilepsia /Convulsiones o ataques			**Sickle Cell Anemia** Anemia de célula falciforme		
Diabetes Diabetes - (azúcar en la sangre)			**Sexually Transmitted Disease (STD)** Enfermedades transmitidas sexualmente		
Kidney Disease Enfermedad del riñón			**HIV / AIDS** VIH / SIDA		
Hepatitis Hepatitis – (enfermedad del hígado)			**Are you pregnant?** ¿Está embarazada?		
Sensitive to Latex Sensitivo al latex			**Are you on birth control pills?** ¿Toma pastillas anticonceptivas?		
Tobacco Use Fuma o mastica tabaco			**Mental/Behavioral/Emotional Conditions** Condición mental/de la conducta/emocional		
ADHD/ADD Trastorno por déficit de atención con hiperactividad / trastorno por déficit de atención			**Osteoporosis (bone density) Medicine** Medicamento para la osteoporosis (densidad ósea)		
Autism Spectrum Disorder Trastorno del espectro autista			**Joint Replacement** Reemplazo de las articulaciones		

Please explain any of the above conditions marked "YES" on the space below:
Si usted ha marcado "sí" en alguna de las preguntas anteriores, favor explique:

_____

Please continue on reverse side of this form. / Favor de continuar al reverso de esta página.

PAL Label

Please continue to answer each question. / Favor continue contestando cada pregunta.

		YES/SI	NO
2.	**Has the patient had any other serious illness?** ¿Ha tenido el paciente otra enfermedad grave? **If YES, please explain** ~ Si su respuesta es "SI", por favor explique: _____		
3.	**Has the patient had any abnormal or prolonged bleeding associated with a previous extraction, surgery or trauma?** ¿Ha tenido el paciente hemorragia anormal o prolongada asociada con extracciones dentales, cirugías o lesiones?		
4.	**Has the patient ever fainted?** ¿Alguna vez se ha desmayado el paciente?		
5.	**Has the patient had pain in the face, cheek, jaws, or joints?** ¿Ha tenido el paciente dolor en la cara, en la mejilla, en la quijada o en las articulaciones?		
6.	**Has the patient had problems with lesions/recurrent infections in their mouth?** ¿Ha tenido el paciente problemas con lesiones o infecciones recurrentes de la boca?		
	IN THE LAST TWO YEARS / Durante los últimos dos años		
7.	**Has the patient had any unintentional weight loss?** ¿Ha bajado de peso el paciente, sin intención?		
8.	**Has the patient been hospitalized? If so, what for?** ¿Ha estado el paciente hospitalizado? ¿Por qué razón? _____		
9.	**Has the patient been on any medicines?** ¿Ha tomado el paciente algún medicamento recetado por el médico?		

10. **Does the patient have any other disease, condition or problem?**
Please explain: _____
_____
¿Presenta el paciente alguna otra enfermedad, condición o problema?
Favor explique: _____

11. **Name, address and phone number of the patient's physician:** _____
Nombre, dirección y teléfono del médico del paciente: _____

12. **Is the patient now having, or ever had any dental problems?**
_____
¿Presenta el paciente actualmente, o ha presentado en el pasado algún problema dental?
_____

13. **Who can we contact in case of an emergency? Name and Phone number:** _____
¿A quién debemos contactar en caso de emergencia? Nombre y número de teléfono: _____

SIGNATURE / FIRMA _____ **Date:** _____
Patient (Parent or guardian - if patient is a minor) **(Fecha)**
Paciente (Padres o encargados – si el paciente es menor de edad)

Recorder: _____ Date: _____

REVIEWED BY:
_____ **Date:** _____

HAMILTON COUNTY HEALTH DEPARTMENT

Permission for Services

PERMISSION FOR MEDICAL AND DENTAL SERVICES

- I do hereby give my consent for Hamilton County Health Department to perform screenings, examinations and/or provide treatments for disease, referrals to other health care practitioners and the necessary follow-up to myself, my child, or ward. I understand that I have the right to refuse any and all treatment and medications.
- I do hereby give my consent for any dental care for myself, my child, or my ward, which the examining dentist feels is necessary, including x-rays, fluoride treatments, restorations, and extractions. I also give my consent for the use of local anesthetics, nitrous oxide-oxygen mixture, and other medication as deemed necessary by the dentist. I understand that I have the right to refuse any and all treatment and medications.

- **Initial and Date:** _____

Medical Photography Consent:

I, _____, Date of Birth _____

Consent to all medical images and or video being made of me or my child/dependent not limited to one date of service. I understand this is for medical treatment, and only viewed by limited staff. I also understand these photographs will not be used for professional education, training, or marketing materials.
I further acknowledge that there will be no compensation for such use of medical photo(s).

This consent maybe revoked at any time with written request by patient.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

- I acknowledge that I have received a copy of the Hamilton County Health Department Notice of Privacy Practices.

- **Initial and Date:** _____

SIGNATURE _____

RELATION TO PATIENT _____ **(complete if other than patient)**

WITNESS _____

Recorded by: (For Staff Use Only) _____

Hamilton County

Health Department

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

The Hamilton County Health Department is able to bill certain insurance plans for some services.

_____(Initial here) If you are not insured, carry insurance that we are not able to file, or if the services being provided are not covered by your insurance, you will be expected to provide payment in full for services at the time they are provided.*

If your insurance covers all or part of the services provided, the Health Department will submit a claim to your health plan for covered services.

Please note, your health plan may deny payment of a claim for one of the following reasons:

- You have not met your full calendar year deductible
- The service is not covered by your plan
- Your coverage was not in effect at the time of service
- You have already received this service within a specified timeframe
- You have other health insurance which must be filed first

The Health Department is pleased to be of service in filing your medical insurance when we can. However, we are not responsible for any limitation in coverage that may be included in your plan.

_____(Initial here) If you are uninsured or if your health plan denies payment for any of the above or other reasons, it is your responsibility to pay for services that have been rendered. If your health plan denies all or part of your claim, you will receive a bill in the mail.

• Does not apply to patients who are actively covered under TennCare, however, we want you to know this information should your health insurance status change.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance plan.

_____ _____

Signature of Patient/Responsible Party Printed name of Signer

_____

Date

HAMILTON COUNTY HEALTH DEPARTMENT
TEXT MESSAGING & VOICE MAIL
Consent Form

Hamilton County Health Department offers patients/clients the opportunity to communicate by text messages or voicemail. Transmitting patient/client information by text messages or voicemail has risks. Hamilton County Health Department will take reasonable means to protect the security and confidentiality of text messages or voicemail. This will include appointment reminders, cancellations, billing/payment reminders, needed treatment.

You have the right to revoke this consent at any time in writing, signed by you. However, such a revocation will not be retroactive and any use of disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Consent for Shared Information with family

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____

I give Hamilton County Health Department permission to leave text messages or voicemail regarding needs listed above.

{} Voicemail **{} Text Message** **{} Both**

Name (Print) **Phone Number**

_____ _____

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____