

## HAMILTON COUNTY HEALTH DEPARTMENT PATIENT REGISTRATION INFORMATION

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

<b>Patient's Name:</b>	<i>(last)</i> _____ <i>(first)</i> _____ <i>(middle)</i> _____	
<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>County:</b>
<b>Phone:</b>	<i>(home)</i> _____ <i>(work)</i> _____ <i>(cell)</i> _____	
<b>Social Security #:</b>		<b>May We Contact You?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Email Address:</b>		
<b>Race: Check One or More</b>	<b>Sex:</b>	<b>Marital Status</b>
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Declined to Specify <input type="checkbox"/> Other	<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
		<b>Ethnicity Is Hispanic?</b>
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<b>Years of Education</b> <small>(Specify Number)</small> _____
		<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> _____

### RESPONSIBLE PARTY

<b>Responsible Party:</b>	<i>(last)</i> _____ <i>(first)</i> _____ <i>(middle)</i> _____	
<b>Date of Birth:</b>	<b>Social Security Number:</b>	<b>Relationship:</b>

### EMERGENCY CONTACT INFORMATION

<b>Emergency Contact Name:</b>	<b>Relationship:</b>	<b>Phone #:</b>
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### INSURANCE POLICYHOLDER (If other than patient)

<b>Policyholder:</b>	<i>(last)</i> _____ <i>(first)</i> _____ <i>(middle)</i> _____	
<b>Social Security Number:</b>		<b>Relationship:</b>
<b>Date of Birth:</b>		<b>Employer:</b>

### FINANCIAL INFORMATION

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

**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**

<b>Nombre del paciente :</b>	<i>(apellidos)</i>	<i>(primer nombre)</i>	<i>(segundo nombre)</i>
<b>Fecha de nacimiento :</b>		<b>Raza:</b>	<input type="checkbox"/> Blanco/a <input type="checkbox"/> Asiático/a <input type="checkbox"/> Afro-Americano/a <input type="checkbox"/> Indio-Americano/a <input type="checkbox"/> Islas del Pacífico
<b>Número de Seguro Social :</b>		<b>Sexo:</b>	<b>Hispano:</b> <input type="checkbox"/> Sí <input type="checkbox"/> No <b>Lengua materna:</b>
<b>Seguro médico incluyendo a TennCare</b>			
<b>¿Tiene usted seguro médico privado?</b>		<input type="checkbox"/> Sí <input type="checkbox"/> No	
<b>Si su respuesta es "sí", ¿pagan ellos por las vacunas?</b>		<input type="checkbox"/> Sí <input type="checkbox"/> No	
<b>Seguro primario:</b>		<b>Seguro secundario:</b>	
<b>Número de identificación del seguro:</b>		<b>Número de identificación del seguro:</b>	
<b>Fecha de efectividad:</b>		<b>Fecha de efectividad:</b>	

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<b>Número de Seguro Social :</b>		<b>Sexo:</b>	<b>Hispano:</b> <input type="checkbox"/> Sí <input type="checkbox"/> No <b>Lengua materna:</b>
<b>Seguro médico incluyendo a TennCare</b>			
<b>¿Tiene usted seguro médico privado?</b>		<input type="checkbox"/> Sí <input type="checkbox"/> No	
<b>Si su respuesta es "sí", ¿pagan ellos por las vacunas?</b>		<input type="checkbox"/> Sí <input type="checkbox"/> No	
<b>Seguro primario:</b>		<b>Seguro secundario:</b>	
<b>Número de identificación del seguro:</b>		<b>Número de identificación del seguro:</b>	
<b>Fecha de efectividad:</b>		<b>Fecha de efectividad:</b>	

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<b>Seguro médico incluyendo a TennCare</b>			
<b>¿Tiene usted seguro médico privado?</b>		<input type="checkbox"/> Sí <input type="checkbox"/> No	
<b>Si su respuesta es "sí", ¿pagan ellos por las vacunas?</b>		<input type="checkbox"/> Sí <input type="checkbox"/> No	
<b>Seguro primario:</b>		<b>Seguro secundario:</b>	
<b>Número de identificación del seguro:</b>		<b>Número de identificación del seguro:</b>	
<b>Fecha de efectividad:</b>		<b>Fecha de efectividad:</b>	

**Nombre de la persona responsable**

**Firma de la persona responsable**

\_\_\_\_\_

\_\_\_\_\_

**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?

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



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

	YES/SI	NO
<b>2. Has the patient had any other serious illness?</b> ¿Ha tenido el paciente otra enfermedad grave? <b>If YES, please explain</b> ~ Si su respuesta es "SI", por favor explique: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Has the patient had any abnormal or prolonged bleeding associated with a previous extraction, surgery or trauma?</b> ¿Ha tenido el paciente hemorragia anormal o prolongada asociada con extracciones dentales, cirugías o lesiones?	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Has the patient ever fainted?</b> ¿Alguna vez se ha desmayado el paciente?	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Has the patient had pain in the face, cheek, jaws, or joints?</b> ¿Ha tenido el paciente dolor en la cara, en la mejilla, en la quijada o en las articulaciones?	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Has the patient had problems with lesions/recurrent infections in their mouth?</b> ¿Ha tenido el paciente problemas con lesiones o infecciones recurrentes de la boca?	<input type="checkbox"/>	<input type="checkbox"/>
<b>IN THE LAST TWO YEARS / Durante los últimos dos años</b>		
<b>7. Has the patient had any unintentional weight loss?</b> ¿Ha bajado de peso el paciente, sin intención?	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. Has the patient been hospitalized? If so, what for?</b> ¿Ha estado el paciente hospitalizado? ¿Por qué razón? _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>9. Has the patient been on any medicines?</b> ¿Ha tomado el paciente algún medicamento recetado por el médico?	<input type="checkbox"/>	<input type="checkbox"/>
<b>10. Does the patient have any other disease, condition or problem?</b> <b>Please explain:</b> _____ _____ ¿Presenta el paciente alguna otra enfermedad, condición o problema? Favor explique: _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>11. Name, address and phone number of the patient's physician:</b> _____ Nombre, dirección y teléfono del médico del paciente: _____		
<b>12. Is the patient now having, or ever had any dental problems?</b> _____ ¿Presenta el paciente actualmente, o ha presentado en el pasado algún problema dental?		
<b>13. Who can we contact in case of an emergency? Name and Phone number:</b> _____ ¿A quién debemos contactar en caso de emergencia? Nombre y número de teléfono: _____		
<b>SIGNATURE / FIRMA</b> _____ <b>Date:</b> _____ Patient (Parent or guardian - if patient is a minor) <b>(Fecha)</b> Paciente (Padres o encargados – si el paciente es menor de edad)		
<b>Recorder:</b> _____ <b>Date:</b> _____		
<b>REVIEWED BY:</b> _____ <b>Date:</b> _____		

**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**

<u>Name</u>	<u>Relationship</u>	<u>Phone Number</u>
_____	_____	_____
_____	_____	_____

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

Voicemail       Text Message       Both

<b>Name (Print)</b> _____	<b>Phone Number</b> _____
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<b>Signature:</b> _____	<b>Date:</b> _____
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<b>Witness Signature:</b> _____	<b>Date:</b> _____
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**HAMILTON COUNTY HEALTH AND SOCIAL SERVICES DIVISION  
CONSENTS AND ACKNOWLEDGEMENTS**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I acknowledge that I have received a copy of the Hamilton County Health and Social Services Division Notice of Privacy Practices.

**PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT**

The Hamilton County Health and Social Services Division is pleased to provide you services today. Please be aware that some services are free and others carry a charge. Your insurance may not cover these charges. For individuals without insurance, services are provided on a sliding fee scale based on family size and income.

I understand that if the service I receive carries a charge, I will be asked to pay in full at the time services are rendered if I do not have insurance, or if the health department does not take my insurance, or if I am requesting a particular service known in advance not to be covered by insurance.

I understand that the Health and Social Services Division will attempt to bill my insurance if they are a contracted provider, but that I still could owe money if my insurance does not pay for any reason.

I understand that a few of many reasons why my insurance may not pay in full are: Service is not covered by my insurance; I have not met my co-pay or deductible. The Health Department is out of network for my insurance. My coverage was not in effect when I received the service. I have received this service in the past within a specified timeframe. I have other insurance which the Health Department does not bill, that must be billed first.

**COMMUNICATION**

The Health and Social Services Division offers patients/clients the opportunity to communicate telephonically and electronically. These communications could include appointment reminders, cancellations, billing/payment reminders, test results and needed treatment. You have the right to consent to these communications and revoke your consent at any time in writing, signed by you. Such revocation will not be retroactive to any prior disclosures.

I give the Health and Social Services Division permission to communicate with me via the following means:

Voicemail     Text Message     Email

I give my permission for the Health and Social Services Division to share my personal health information with the following individual(s):

Name:  Relationship:  Phone:

Name:  Relationship:  Phone:

**MEDICAL/DENTAL SERVICES CONSENT**

\_\_\_\_\_ **Medical:** I do hereby give my consent for the Health and Social Services Division to perform screenings, immunizations, examinations and/or provide treatment 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/medications.

\_\_\_\_\_ **Dental:** 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.

\_\_\_\_\_ **Behavioral Health:** I do hereby give my consent for counseling and medication management services and to other health care practitioners and the necessary for treatment purposes.

**Sexual/Reproductive Health Services:** I 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 the image is **for medical treatment**, and will 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.

\_\_\_\_\_ **I consent** \_\_\_\_\_ **I do NOT consent**

**COMMUNITY HEALTH AND SOCIAL SERVICES CONSENT**

\_\_\_\_\_ I consent to the provision of social and/or case management services to myself or minor child.

\_\_\_\_\_ I understand that health screening questions may be asked before in-person visits and will be answered honestly to the best of my knowledge. I understand that home visits may be rescheduled or held virtually if the response to any of the questions is "yes".

\_\_\_\_\_ I understand that due to illness or other unforeseen events, the option is available for personal visits to be conducted using interactive video conferencing or phone calls. Group connections may also be offered using interactive video conferencing.

\_\_\_\_\_ I understand that after the third missed appointment, if unable to reschedule, I may be contacted and notified for the termination of services.

Photographs are often taken during social services activities and events. Social Services may use such photographs for any lawful purpose including, but not limited to, such purposes as publicity, illustration, advertising and website content. Your authorization for us to use any of these photographs of your child/children/family for any of these purposes is necessary.

\_\_\_\_\_ **I consent** \_\_\_\_\_ **I do NOT consent**

**SIGNATURE**

My signature below indicates that I have read and given my consent and or acknowledgement as indicated by my initials.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** \_\_\_\_\_ (complete if other than patient)

**WITNESS** \_\_\_\_\_ **NC-02 (Rev.1.26)**