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
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:					