



# Patient Registration

Allergies \_\_\_\_\_ Reaction \_\_\_\_\_

## Patient Information

Today's date: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Patient's Legal Name: First \_\_\_\_\_ Last \_\_\_\_\_ SSN: \_\_\_\_\_

Patient's Nickname: \_\_\_\_\_ Maiden Name : \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Other names you have used: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_ Citizen of US: Yes \_\_\_\_\_ No \_\_\_\_\_

**Race:** (circle one) White Black Native American Asian/Pacific Island Chinese Japanese Hawaiian Filipino Asian Indian Korean Samoan Vietnamese Guam Other: \_\_\_\_\_

**Ethnicity:** (circle one) Non-Hispanic Mexican Puerto Rican Cuban Central/South American Other: \_\_\_\_\_

**Are you currently enrolled in WIC** (Women, Infant, and Children)? Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes, how long \_\_\_\_\_

**Marital Status:** S M Sep D W N/A (minor) If married, spouse's name: \_\_\_\_\_

**In case of an EMERGENCY please NOTIFY:** Name \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Other \_\_\_\_\_ Relationship: \_\_\_\_\_

### **Park University Students Only:**

Please circle if you are a: Resident Commuter International Student Athlete

Student ID #: \_\_\_\_\_

## Insurance Information:

**Insurance:** (circle one) Medicaid Medicare Uninsured Bollinger Other Private \_\_\_\_\_

**Does your insurance cover:** Medicaid Spend Down? Yes No Hospitalization Only? Yes No

Immunizations? Yes No Labs? Yes No

(If No = Underinsured) Office Visits? Yes No

Womens Health Visits? Yes No

**Gross Household Income:** per year \$ \_\_\_\_\_ per month \$ \_\_\_\_\_ **Family Size:** \_\_\_\_\_

### **Fill out ONLY if you have Medicaid, Medicare or Bollinger Insurance**

**Medicaid/Medicare** Plan Name: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Bollinger** Policy #: \_\_\_\_\_ Student ID #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

I hereby authorize treatment deemed necessary by the Platte County Health Department Provider. I also authorize the release of my medical records to any Insurance Company with whom I have insurance coverage or to any company to which I have applied for coverage. I understand that I am responsible for ANY amount not covered by insurance if applicable.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**IF PATIENT IS MINOR**

Name of legal guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name(s) of person with minor: \_\_\_\_\_

Relationship(s) to minor: \_\_\_\_\_

Address (if different than patient): \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ DOB: \_\_\_\_\_

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**Platte County Health Department has offered me a copy of their "Notices of Privacy Practices"**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I hereby grant permission to the Platte County Health Department to obtain specimens and to perform tests for sexually transmitted diseases. I freely accept the medical and laboratory services provided to me. I am fully aware that all positive test results will be reported to the Missouri Department of Health and if HIV positive or TB positive, I will be offered management services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Nurse/Witness: \_\_\_\_\_ Date: \_\_\_\_\_

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All services are confidential; however, in the event that we do need to contact you regarding a lab result, may we identify ourselves as the Platte County Health Department? Yes \_\_\_\_\_ No \_\_\_\_\_

Please indicate where we CAN call/leave a message with you:

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Work: \_\_\_\_\_ Other: \_\_\_\_\_

Please list to whom your medical records may be released to:

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_