

Blue Ridge Community Health Services, Inc.

Patient Registration Form

RESPONSIBLE PARTY INFORMATION (Parent or Guardian or Self.)					
NAME FIRST		MI		LAST	
STREET ADDRESS		CITY		STATE	ZIP COUNTY
PO BOX (IF APPLICABLE)		CITY		STATE	ZIP COUNTY
SOCIAL SECURITY NO.	SEX <input type="checkbox"/> F <input type="checkbox"/> M	BIRTHDATE	MARITAL STATUS Single Married Divorced Widowed Separated		
EMPLOYMENT STATUS (<i>Circle One</i>) Full Time Student (F) Part Time Student (P) Full Time (1) Part Time (2) Unemployed (3) Self Employed (4) Retired (5) Active Duty (6)				WORK PHONE	
EMPLOYER NAME			EMPLOYER ADDRESS		
AGRICULTURAL WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> MIGRANT					
PATIENT INFORMATION					
NAME FIRST		MI		LAST	
				RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	
STREET ADDRESS		CITY		STATE	ZIP COUNTY
PO BOX (IF APPLICABLE)		CITY		STATE	ZIP COUNTY
HOME PHONE	SOCIAL SECURITY NO.	SEX <input type="checkbox"/> F <input type="checkbox"/> M	BIRTHDATE	PRIMARY LANGUAGE	
MARITAL STATUS Single Married Divorced Widowed Separated			EMPLOYMENT STATUS (<i>Circle One</i>) Full Time Student (F) Part Time Student (P) Full Time (1) Part Time (2) Unemployed (3) Self Employed (4) Retired (5) Active Duty (6)		
EMPLOYER NAME			EMPLOYER ADDRESS		WORK PHONE
RACE <input type="checkbox"/> 2 BLACK/AFRICAN AMERICAN <input type="checkbox"/> 1 WHITE (not Hispanic) <input type="checkbox"/> 6 HISPANIC/LATINO <input type="checkbox"/> 8 ASIAN/PACIFIC ISLANDER <input type="checkbox"/> 4 AMERICAN INDIAN <input type="checkbox"/> 9 OTHER			AGRICULTURAL WORKER <input type="checkbox"/> SEASONAL <input type="checkbox"/> MIGRANT		SHELTER TYPE <input type="checkbox"/> DOUBLING UP <input type="checkbox"/> STREET <input type="checkbox"/> SHELTER <input type="checkbox"/> TRANSITIONAL <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER
EMERGENCY CONTACT		RELATIONSHIP TO PATIENT			PHONE
INSURANCE COMPANY					
PRIMARY INSURANCE		ID#	GROUP #	INSURANCE COMPANY ADDRESS	
NAME OF INSURED		INSUREDS EMPLOYER		RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____	
SECONDARY INSURANCE		ID#	GROUP #	INSURANCE COMPANY ADDRESS	
NAME OF INSURED		INSUREDS EMPLOYER		RELATIONSHIP TO RESPONSIBLE PARTY <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER _____	
AUTHORIZATION AND ASSIGNMENT					
<p>I consent to the medical/dental examination, treatment, and procedures which may be performed during the office visit, including emergency treatment considered necessary by the medical or dental provider. I understand that if an invasive procedure is necessary, a specific consent form will be discussed with me at that time. I give permission to BRCHS to release any medical/dental information to Medicare, Medicaid, or the insurance company that is needed to receive payment for medical or dental services rendered to me or other persons listed on this Patient Registration Form. I understand that I am responsible and are required to pay to BRCHS any co-pays, deductibles, and charges not covered by Medicare, Medicaid, insurance, or any balances due to BRCHS. Payment of deductibles and copayments are expected at the time of service.</p>					
SIGNED: X		DATE:		WITNESS: DATE:	
FOR INTERNAL USE ONLY					
ACCOUNT NO.	CHART NO.	COPY OF INSURANCE OBTAINED	INSURANCE VERIFIED	DATA ENTRY CLERK INITIALS	