JACKSON-HINDS COMPREHENSIVE HEALTH CENTER REGISTRATION

FORM 1

Please check one: New Patient_____ Established Patient _____

Telephone Numbers

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Birth Date:_____**Social Security Number:**_____

Email Address_____

Cell Phone: _____

Home Phone: _____

Work Phone: _____

Person to Contact in Case of Emergency:

_____

Phone No.

Martial Status (please circle your answer): Married-------Single-------Divorced-------Widow-------Separated

Student (please circle your answer): Yes----No: If Yes, School's name_____

Jackson Hinds is required to report sexual orientation and gender identify information about the population we serve. Please circle your answers below:

Gender : Female----Male----Transgender Male(Female to Male)----Transgender Female(Male to Female)----Other----Choose not to disclose

Sexual Orientation : Lesbian------Straight------Bisexual------Something Else------Don't Know------Choose Not to Disclose

Race:
- **m African/Black American**
- **m White**
- **m Hispanic**
- **m Asian/Pacific Islander**
- **m American Indian/Alaskan Native**
- **m Native Hawaiian**

Your Primary Language:
- **m English**
- **m Spanish**
- **m Other:**

Are you of Hispanic or Latino Descent?

If Yes, Check One:
- **O African American**
- **O White**
- **O American Indian**

Do You Need an Interpreter? Check one:
- **O No**
- **O Yes, Specify Interpretation Needed:**_____

Please Check Your Living Arrangement/Status:
- **O Homeless Shelter**
- **O Doubling Up**
- **O Transitional**
- **O Street**
- **O Own/Rent**

Are you a Veteran? Yes or No:

What Health Insurance Coverage Do You Have? (Check all that apply) m Medicaid m Medicare m Private Health Insurance

Place of Employment _____

Medicaid No. _____ **Policy #** _____

Medicare No. _____ **Policy #** _____

Medical Insurance (Primary) _____ **Policy #** _____ **Group #**_____

Medical Insurance (Secondary) _____ **Policy #** _____ **Group #**_____

Dental Insurance _____ **Policy #** _____ **Group #**_____

Please Provide the Following Information on the Responsible Party To Be Billed if not patient

		Phone No.	Social Security No.	Birth Date
Parent or Guardian:	_____	_____	_____	_____

I, the patient or parent/guarantor, hereby authorize any holder of information about me to release to Medicaid, Medicare or insurance provider any information needed for settlement of my claims. I understand approved claims will be deducted from my allocated benefits whether they were rendered in one of our clinics or mobile health facilities. I am requesting that all health insurance benefits be made payable to Jackson Hinds Health Center.

Signed:_____ **(Patient or Parent/Guardian)** **Date:**_____