St. Clair County Health Department

Client Registration

Date: ___/___/_____ (MM DD YYYY) Client Sex: Male Female (Circle One) Date of Birth: ___/___/_____ (MM DD YYYY)

Client Name: _____, _____ _____
Last Name (Family Name) *First Name (Given Name)* *MI*

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Phone - Home: _____ Cell: _____ Work: _____

E-mail: _____

Employer Name and Address: _____

Spouse's Name: _____

Family Physician *(if applicable)*: _____

Emergency Contact *(Other than Spouse)*: _____

Relationship to Client: _____ Phone Number: _____

CLIENT'S RACE: *Black/African American Asian/Pacific Islander Latino White Other:*
(optional) ***(Circle One)***
CLIENT'S ETHNICITY: *Hispanic* *Yes/No* ***(Circle One)***

CLIENT INSURANCE: Does the client have, or is the client covered by health insurance? *(Circle One)* Yes No

1. **PRIMARY** Insurance Company Name: _____

   Address/City/State/Zip _____

   Policy Holder *(Insured's Name)*: _____ Policy Holder Date of Birth _____
   Policy Number: _____ Group Number _____

   What relationship is Policy Holder to the Client? *(Circle One)*: Spouse Child Self Other: _____

   Is policy through Employer? If Yes, Employer's Name: _____

2. **SECONDARY** Insurance Company Name: _____

   Address/City/State/Zip _____

   Policy Holder *(Insured's Name)* _____ Policy Holder Date of Birth _____

   Policy Number _____ Group Number _____

   What relationship is Policy Holder to the Client? *(Circle One)* Spouse Child Self Other: _____

   Is policy through Employer? If Yes, Employer's Name: _____

   Effective Date of Policy: _____ Work Phone: _____

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MESSAGES REGARDING THE CLIENT:

__ **Yes,** *St. Clair County Health Department* has my permission to leave voice-mail messages in regard to appointments, lab results and other information related to client visits.
My preferred number for messages is: _____

__ **No,** I would prefer that *St. Clair County Health Department* not leave *detailed* information on my voice-mail other than messages for me to call the health department.

CONSENT TO TREAT: I authorize the *St. Clair County Health Department's* healthcare providers to administer services as deemed necessary for care of the client named above. I certify that I am the client or parent or legal guardian of the client. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the services.

ASSIGNMENT OF BENEFITS: All professional services rendered are charged to the client. Necessary forms will be completed to help expedite insurance carrier payments. The client/parent/responsible party is responsible for any unpaid balances unless eligible for a fee waiver under the St. Clair County Health Department hardship program. Co-payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid, or other insurance company benefits be made to *St. Clair County Health Department* for any services furnished to me by the *St. Clair County Health Department.* Regulations pertaining to Medicare and Medicaid assignment of benefits apply.

The information you provide will be kept confidential. Your signature indicates that all information provided above is true and accurate:

_____ _____
Signature of Client or Legal Representative *Date*

If client is under the age of 18:

Full Name of Parent or Legal Representative: _____

Address if different than your client: _____

City _____ State _____ Zip _____ Day Phone _____

FOR OFFICE USE ONLY: Employee Signature: _____ Date_____