KANAWHA-CHARLESTON HEALTH DEPARTMENT
REGISTRATION FORM

SECTION 1. Patient Information

Patient's Name_____ Date of Birth _____ Age _____
(Last) (First) (Middle)
Address_____
(Street Address) (City) (State) (Zip)
Home Phone _____ Work Phone _____ Cell Phone _____

Last 4 Digits of Social Security Number _____ Race _____ Sex _____ Marital Status _____

SECTION 2. Permission to Contact You

KCHD has my permission to contact me by (please check all that apply):
Home Phone ❑YES ❑NO Cell Phone ❑YES ❑NO Email ❑YES ❑NO_____
Work Phone ❑YES ❑NO Mail ❑YES ❑NO Other _____

B. ❑ DO NOT CONTACT ME DIRECTLY (Must specify alternate contact)
Alternate Contact: Name _____ Phone Number _____

Address _____

SECTION 3. Health Insurance Coverage (Must Be Completed)

What type of insurance do you have?
❑PEIA ❑Carelink Coventry ❑BCBS
❑Carelink Medicaid ❑Unicare Medicaid ❑WV Medicaid
❑Other _____ ❑None

ID Number _____ Group Number (if any) _____

Does your insurance cover immunizations? ❑YES ❑NO
Does your insurance cover birth control supply? ❑YES ❑NO

If you are requesting services through WV Family Planning (FP), Breast & Cervical Cancer Screening Program (BCCSP), or Vaccines for Children (VFC) you must provide the following financial information in Section 4.

SECTION 4. List ALL PERSONS living in your home AND their gross monthly income from ALL SOURCES

Name	Relationship to Person Receiving Services	Name of Employer or Source of Income	Gross Monthly Income (Before Taxes)

I hereby grant permission to Kanawha-Charleston Health Department to have such diagnostic and/or treatment procedures performed on the above-named patient as may be deemed necessary by duly authorized clinician of said Health Department. I further grant authority to release such medical information regarding the above named patient as may be requested by other physicians or other health, welfare, or veterans agencies to which I have applied or may in the future apply for service or assistance.

I have been informed that this clinic assures patient confidentiality and provides safeguards against the invasion of personal privacy, as required by the Privacy Act of 1974 and Health Information Portability and Accountability (HIPPA) regulations. All information, which may be identified with me, will be considered privileged and confidential. This information will only be used with the understanding that confidentiality will be maintained.

I understand that if I am dissatisfied with the services rendered at this facility or have been discriminated against because of race, creed, color, or national origin, I may present my complaint to either the Director or Nursing or Director of Business Support Services.

THE FOLLOWING STATEMENT REQUIRES YOUR SIGNATURE
My signature on this document verifies that I have read and understand the above information. To the best of my knowledge and belief, the information I have provided concerning income and insurance is true, correct and complete. Federal law prohibits falsification of this information.

_____ _____ _____
Signature of Patient/Parent/Guardian Date Witness