Community Health Center of Central Missouri

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: **First:** **Middle:**	☐ Mr. ☐ Mrs.	☐ Miss ☐ Mr.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Social Security Number:	**Home Phone** ( )	Cell Phone ( )	**Birth date:** / /	Age:	**Sex:** ☐ M ☐ F
Street Address:	**City, State:**	**County:**	**Zip Code:**	
Ethnicity (circle one) White Black Native American Asian Other **Hispanic/Latino/Latina** ☐ Yes ☐ No	**Are you a Veteran?** ☐Yes ☐No	Are you attending School? ☐ Yes ☐No ☐ Full time ☐ Part time		
Are you Working? ☐Yes ☐ N ☐ Full time ☐Part time	Employer:	Employer phone no: ( )		

Pharmacy of Choice: ______________________ **Preferred Hospital:**____________________ **Primary Care Physician:**_______________

Preferred Method of Appointment Reminder: ☐ Telephone Call ☐ Text Message (____)______________ Carrier:_________________

☐ E-Mail:__________________________

GUARANTOR INFORMATION

Person responsible for bill:	**Birth date:** / /	Address (if different):	Home phone: ( )
Is this person a patient here? ☐ Yes ☐ No	Cell phone ( )		
Occupation:	Employer:	Employer address:	Employer phone ( )

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Please select your primary insurance:☐ Uninsured ☐ Medicare ☐ MO Health Net/Medicaid ☐Private/Commercial (list name):____________

Subscriber's Name:	Subscriber DOB: / /	Subscriber's S.S.	Policy No:	Group No:
Patient's Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Please select your secondary insurance:☐ Uninsured ☐ Medicare ☐ MO Health Net/Medicaid ☐Private/Commercial (list name):__________

Subscriber's Name:	Subscriber DOB: / /	Subscriber's S.S.	Policy No:	Group No:
Patient's Relationship to Subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

ANNUAL INCOME

Locate family size and ***then circle*** the annual income range on the line that best represents your household

	1	2	3	4	5	6	7	8
A	$0-11,490	$0-15,510	$0-19,530	$0-23,550	$0-27,570	$0-31,590	$0-35,610	$0-39,630
B	$11,491-17234	$15,511-23,264	$19531-29,294	$23,551-35,324	$27,571-41,354	$31,591-47384	$35,611-53,414	$39,631-59,444
C	$17,235-22979	$23,265-31,019	$29,295-39,059	$35,325-47,099	$47,355-55,139	$47,385-63,179	$53,415-72,219	$59,445-79,259
D	$22,980 & up	$31,020 & up	$39,060 & up	$47,100 & up	$55,140 & up	$63,180 & up	$71,220 & up	$79,260 & up

How did you hear about us? ☐ TV ☐ Radio ☐ Newspaper ☐ Website ☐ Friend ☐ Referral

☐ Other (Please be specific)_______________________

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone: ( )	Work phone: ( )	Cell phone: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the medical provider or I have the permission of the person providing insurance benefits for such charges to be billed to such insurance. I understand that I am financially responsible for any balance. I also authorize Community Health Center of Central Missouri or insurance company to release any information required to process my claims. I hereby consent to the above named patient, whose name appears on this form, receiving medical care considered advisable by the attending medical provider of the Community Health Center of Central Missouri and attest that I have the legal authority to make health care decisions and act on behalf of the patient if the patient is a minor or otherwise incapacitated. I further recognize that CHCCMO is not responsible for any personal property brought onto CHCCMO's premises.

Patient/Guardian signature ***Date***