

Hoke County Health Department

Patient Registration Form-Mass Vaccination

Patient Information

Last Name:	First Name:	M.I.:	Previous Name:
Mailing Address:			
City/State/Zip:			
Home Phone:	Cell Phone:	Work Phone:	
Date of Birth:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status:	SSN #:		
Person responsible for the bill (ONLY IF DIFFERENT THAN THE PATIENT):			
Last Name:		First Name:	
Date of Birth:	SSN #:	Phone:	
Address of Person Responsible (if different from patient):			
City/State/Zip:		Relationship to Patient:	

Additional Information (PLEASE FILL OUT ALL FIELDS BELOW):	
Email Address:	Can we leave a message regarding your medical care & test results? <input type="checkbox"/> Yes <input type="checkbox"/> No
Race (please select): <input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> Other <input type="checkbox"/> Decline	Ethnicity (please select one): <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline
Preferred Language (please select one): <input type="checkbox"/> English <input type="checkbox"/> Bosnian <input type="checkbox"/> Indian (including Hindi & Tamil) <input type="checkbox"/> Russian <input type="checkbox"/> Sign Language <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	

Insurance Information

Primary Policy Holder Information (ONLY IF DIFFERENT THAN THE PATIENT OR RESPONSIBLE PARTY):	
Primary Medical Insurance	Secondary Medical Insurance
Ins. Co. Name:	Ins. Co. Name:
Policy Holder Name:	Policy Holder Name:
Policy Holder DOB:	Policy Holder DOB:
Policy Holder Relationship to Patient:	Policy Holder Relationship to Patient:
Policy Holder Address:	Policy Holder Address:
Group Number, Policy Number, Medicaid Number:	Group Number, Policy Number, Medicaid Number:

I have read and agree to the Hoke County Health Department's (HCHD) payment policy. I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to HCHD all money to which I am entitled for medical expenses related to the services performed from time to time by HCHD, but not to exceed an indebtedness to HCHD. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to HCHD. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Guardian: _____

Date: _____