Onslow County Health Department **Patient Registration Form**

A. PATIENT INFORMATION

Appointment Date	Patient's Full Name (Last, First Middle Initial)	Maiden Last Name	Birth Date (mm/dd/yyyy)

How you ever applied with N.C. Department of Social Services for Medicaid, Food Stamps or WFFA assistance? Yes ☐ No ☐

Military Affiliation	Active Duty ☐	Retiree ☐	Dependent (Spouse) ☐	Dependent (Child) ☐	Dependent (Other) ☐

SSN (xxx-xx-xxxx)	Male ☐ Female ☐	Home Phone (xxx-xxx-xxxx)	Cell Phone (xxx-xxx-xxxx)	Work Phone (xxx-xxx-xxxx)

White ☐	Black / African American ☐	American Indian / Alaska Native ☐	Asian ☐	Native Hawaiian/Other Pacific Islander ☐	Unknown ☐

Complete Mailing Address	County of Residence	City	State	Zip

Preferred Language	English ☐	Spanish ☐	Other Language:

Hispanic Cuban ☐	Hispanic Mexican American ☐	Hispanic Other ☐	Hispanic Puerto Rican ☐	Not Hispanic / Latino ☐	Unreported ☐

Employment Status (1)	Armed Forces ☐	F/T 32+ hrs/wk ☐	P/T 1-15 hrs/wk ☐	P/T 16-32 hrs/wk ☐	Unemployed, seeking work ☐	Unemployed, not seeking work ☐

Living Arrangements	Alone ☐	Spouse ☐	Both Parents ☐	Mother ☐	Father ☐	Other Relatives ☐	Non Relatives ☐

Mother's Maiden Name assists in client de-duplication process in the N.C. Immunization Registry (NCIR)	Mother's Maiden Last Name	Current Last Name	First Name

B. EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Relationship to Patient	Phone # w Area Code

C. RESPONSIBLE PARTY – (IF PATIENT IS MINOR CHILD THIS SECTION MUST BE COMPLETED)

If not a minor child, the patient above is considered the responsible party, and this section does not need to be completed.

Name of person responsible for this account	Relationship to patient	SSN (xxx-xx-xxxx)	Birth Date (mm/dd/yyyy)
Address	City	State	Zip
Employer	Home Phone	Work Phone	Cell Phone

D. PRIMARY INSURANCE INFORMATION *(Please provide a copy (front / back) of your medical insurance card / military ID card)*

Name of Insurance Carrier	Primary Subscriber's Name, *if other than patient*		
Primary Subscriber's Birth Date	Policy #	Group #	Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other:
Name of Employer			Work Phone (xxx) xxx-xxxx

E. ADDITIONAL INSURANCE INFORMATION *(Please provide a copy (front / back) of your medical insurance card)*

Name of Insurance Carrier	Primary Subscriber's Name, *if other than patient*		
Primary Subscriber's Birth Date	Policy #	Group #	Relationship to patient ☐ Self ☐ Spouse ☐ Child ☐ Other:
Name of Employer			Work Phone (xxx) xxx-xxxx

F. CLIENT HOUSEHOLD (Adult Health, Child Health, Family Planning, Health Promotions and Maternal Health services)

Persons living in the home, including patient	**DOB(xx/xx/xx) or Age**	**Gender**	**Relationship to Patient**
		M ☐ F ☐	SELF
		M ☐ F ☐	
		M ☐ F ☐	
		M ☐ F ☐	
		M ☐ F ☐	