Cabarrus Health Alliance Patient Registration

Please complete all fields **Date:_____**

Patient name: _____
First Middle Last

Date of Birth MM/DD/YY_____ Patient Social Security Number: _____

Address: _____ P.O. Box: _____

City: _____ State: _____ Zip code: _____ County: _____

Home Phone: _____ Work: _____ Cell: _____

Sex:_____ Marital status: _____ Race: _____ Hispanic: ◯ Yes ◯ No

Do you have insurance? ◯ Yes ◯ No if yes name of insurance: _____
(**Please note we only accept BCBS, Wellpath, Cigna, Aetna, MedCost and Perdue**)

Do you have Medicaid? ◯ Yes ◯ No

Do you have Medicare? ◯ Yes ◯ No

**** If you have insurance or Medicaid; please include a copy, of the front and back of the card, along with the completed forms. Please also be prepared to provide your card at check in.**

Parent's/Legal Guardian's Names (if patient is a minor):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Emergency Contact: Name:_____Phone:_____
(This number needs to be a different than the numbers provided above)

Allergies: ◯ Yes ◯ No

(if yes please list):_____

Mother's maiden last name _____ Mother's first name_____
(This information is used for identification purposes in the North Carolina Immunization Registry.)

CONSENT FOR VACCINATION – NOTICE OF PRIVACY PRACTICE

I have been provided access to the Cabarrus Health Alliance Notice of Privacy Practices. I agree for Medicare, Medicaid and/or Insurance, if applicable, to be billed and I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the Cabarrus Health Alliance.

Signature _____ Date:_____
Signature of recipient or authorized person (*Age under 18 years requires parental consent)