Logan County Health Department
CLIENT REGISTRATION

Last Name:_____First:_____ Middle Initial:____

Maiden Name:_____ Gender: Male_____Female_____ Age:_____

Date of Birth:_____ County_____

Address:_____

City:_____ State:_____ Zip Code_____
Phone number(s): Home #_____ Cell #_____ Work #_____
OK to leave a phone message for you? Yes_____ No_____
OK to send mail to you at the above address? Yes_____ No_____
If No, how may we best contact you?_____

Physician:_____ Allergies:_____
Are you under a physician's care for any medical condition? Yes_____ No_____

Emergency Contact Name:_____ Phone:_____

Address:_____Relationship:_____

Race: (Please select ALL that apply) American Indian/Alaska Native_____ Asian_____

Black or African American_____ Native Hawaiian/Pacific Islander_____ White_____

Hispanic/Latino Origin? Yes_____ No_____ If Yes, please select one of the following:
Mexican_____ Cuban_____ Puerto Rican_____ Central/So. American_____Other_____

Is English your primary language? Yes_____ No_____
Marital Status: Married_____ Widowed_____ Divorced_____ Single_____Separated_____
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Health Insurance: (Please select all that apply and present your insurance card)
Title XIX_____ Title XXI____ Medicare____ No Coverage____ Private Insurance_____

Total (Gross) Household Income: $_____ per week/ month/ year (circle one)
Number of persons supported by this income: _____persons

Health Care Guarantor – Person responsible for paying your bill:
Name:_____ Social Security #_____
Date of Birth:_____ Relationship_____
Address:_____City_____Zip:_____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

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Name:_____ Date of Birth:_____

Statement of Service and Access to Care

The Logan County Health Department is a non-profit, public sponsored health facility providing preventive/wellness care and community health education to residents of Logan County. We are supported by Logan County tax dollars, State and Federal funding, insurance reimbursements, and client payments and donations. Ability to pay is never a barrier to receiving care. Payment plans and charitable options are available. Our staff can help you in finding the health care resources you need.

Consent for Service and Evaluation

I am voluntarily consenting to receive health care services at the Logan County Health Department. I understand that these services may include preventive and wellness care, health status evaluation, routine physical examination, lab work and immunizations. I understand that services provided by the Logan County Health Department do not replace comprehensive diagnostic and treatment services provided by my physician.

Client Name (please print)_____

Signature_____Date_____

Relationship to Client_____

Authorization for Billing and Payment of Medical Benefits

I, (print your name)_____, authorize the Logan County Health Department to bill and accept payment from insurance and/or government benefit plans for services provided by the Logan County Health Department to (print client's name)_____. I understand that the Logan County Health Department accepts Medicaid, Medicare and Farm Worker assignment as payment for covered services. Services that are not covered by insurance will be billed for payment. Any balance due after private insurance payment will be the Client or Guarantor responsibility.

Signature_____Date_____

Relationship to Client_____