Georgia Department of Public Health
West Central Health District

Registration and Consent Form
Outreach Child Health Clinics

For Office Use Only
Patient #

Randolph County Health Department – 207 N Webster Street, Cuthbert, Georgia 39840
Phone: 833-337-1749

SECTION I DEMOGRAPHIC INFORMATION

DATE		**IDENTIFICATION** *(Check One)* Driver's License ☐ Work ID ☐ Military ID ☐ Other _____	
PATIENT'S NAME (Last) (First) (Middle)			
PATIENT'S DATE OF BIRTH	**Age**	**PHONE NUMBER** ( )	**GENDER** *(Please Circle One)* MALE FEMALE
PATIENT'S ETHNICITY *(Please Circle One)* Not Hispanic/Latino Hispanic /Latino		**PATIENT'S RACE** *(Please Check ALL That Apply)* Black/African American ☐ White ☐ American Indian ☐ Asian ☐ American Indian ☐ Alaska Native ☐ Hawaiian/Polynesian ☐ Multicultural ☐ Other:_____	
PATIENT'S HOME ADDRESS (No PO Box please)			
CITY	**STATE**	**ZIP CODE**	**COUNTY**
TOBACCO USE *(Please Check Response):* YES☐ NO☐ If yes: smoke, smokeless, other_____		**IS THE PATIENT** *(Please circle one)* Single Married Separated Divorced Widowed	
PARENT OR GUARDIAN (if applicable) (Last) (First) (Middle)			
PATIENT'S PHYSICIAN		**YOUR RELATIONSHIP TO THE PATIENT:**	
YOUR NAME, IF NOT PARENT OR GUARDIAN (if applicable (Last) (First) (Middle)			

SECTION II PAYMENT TYPE

SOURCE OF PAYMENT *(Please Check One)* Cash ☐ VISA ☐ MasterCard ☐ Discover ☐	**DOES THE PATIENT HAVE INSURANCE?** YES ☐ NO ☐

MEDICAL INSURANCE INFORMATION

NAME OF SUBSCRIBER_____ **DOB**_____**GROUP**_____ **MEMBER ID #**_____

_____ **NAME OF INSURANCE**_____

RELATIONSHIP TO PATIENT

DOES THE PATIENT HAVE A SECONDARY INSURANCE: YES ☐ NO ☐

NAME OF SUBSCRIBER_____ **DOB**_____**GROUP**_____ **MEMBER ID #**_____

_____ **NAME OF INSURANCE** _____

RELATIONSHIP TO PATIENT

SECTION III CONSENT AND HIPAA PRIVACY ACKNOWLEDGEMENT

I have read and completed the Hearing, Vision, and Dental Questionnaire to the best of my knowledge. By signing below, I acknowledge I have been offered/given the privacy notice and I authorize permission for the Hearing, Vision, and Dental screening, Lead screening, and Hemoglobin screening to be completed if indicated.

DATE	PATIENT OR PARENT/GUARDIAN SIGNATURE	NURSE'S SIGNATURE

Randolph County Health Department

Georgia Department of Public Health
West Central Health District

207 North Webster Street Cuthbert, Georgia 39840
Telephone: 833-337-1749 Fax: (229) 732-5007

Hearing History Questionnaire

1. Who is your child's pediatrician? _____
2. Has the child ever had a hearing screening before? YES NO
3. If so, when? _____ What were the results? _____

Vision History Questionnaire

4. Has your child ever had a vision screening before? YES NO
5. If so, when? _____ What were the results? _____
6. Does the child wear prescription glasses or contacts? YES NO
7. If so, did the child bring their glasses or contacts today? YES NO

Dental History Questionnaire

8. Who is your child's Dentist? _____ YES NO
9. When was your child last seen by their Dentist? _____

Form completed by: _____ Date: _____

Form reviewed by: _____ Date: _____