BEAUFORT- JASPER – HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.

NAME:_____

CHART #:_____

DOB:_____

DATE:_____

REGISTRATION FORM

Today's Date: _____ Review Date: _____

FOR REGISTRATION PERSONNEL ONLY – DO NO WRITE IN THIS SPACE

Which of our centers have you visited: (Please check the location)

☐ Port Royal Center ☐ Hampton Center ☐ Chelsea Center ☐ Hardeeville Center
☐ Sheldon Center ☐ Ridgeland Center ☐ St. Helena Center ☐ Estill Center

PATIENT INFORMATION				
Last Name	First Name	Middle Initial	Social Security Number	
Street Address	City	State	Zip	County
Mailing Address/PO Box	City	State	Zip	County
Home Phone ( )	Work Phone ( )	Date of Birth	Sex	Driver's License Number
Email Address:				
Relationship to Responsible Party ☐ Self ☐ Spouse ☐ Child ☐ Other				
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated				
Race ☐ Black ☐ Hispanic/Latino ☐ White ☐ American Indian ☐ Chinese ☐ Japanese ☐ Filipino ☐ Asian ☐ Pacific Islander ☐ Undeclared ☐ Nat Hawaiian				
Primary Language ☐ English ☐ Spanish ☐ Other				
Emergency Contact	Phone Number			

RESPONSIBLE PARTY INFORMATION (Enter name of person financially responsible for your account)					
Last Name	First Name	Middle Initial	Social Security Number		
Street Address	City	State	Zip	County	
Mailing Address/PO Box	City	State	Zip	County	
Home Phone ( )	Work Phone ( )	Date of Birth	Sex	Driver's License Number	Marital Status
Employer Name	Employer Address & Phone Number				

AGRICULTURAL WORKER	
☐ No ☐ Seasonal ☐ Migrant ☐ Other ☐ Employed Farm-worker ☐ Unemployed Farm-worker	☐ Not Homeless ☐ Homeless Shelter ☐ Transitional ☐ Other ☐ Doubling Up ☐ Street

INSURANCE COMPANY			
Primary Insurance	ID#	Group#	Insurance Company Address
Name of Insured	Insured's Employer	Relationship to Responsible Party ☐ Self ☐ Spouse ☐ Child ☐ Other	
Secondary Insurance	ID#	Group#	Insurance Company Address
Name of Insured	Insured's Employer	Relationship to Responsible Party ☐ Self ☐ Spouse ☐ Child ☐ Other	

BEAUFORT- JASPER – HAMPTON
COMPREHENSIVE HEALTH SERVICES, INC.

NAME:_____

CHART #:_____

DOB:_____

DATE:_____

CONSENT FOR TREATMENT

I hereby authorize Beaufort-Jasper-Hampton Comprehensive Health Services, Inc., to provide medical surgical, dental and hospital treatment including – but not limited to – an x-ray, examinations and injections and laboratory work to include routine, opt-out HIV testing as may be ordained as advisable or necessary by the attending professional staff.

Signature: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other _____

GENERAL RELEASE/ASSIGNMENT OF BENEFITS

I hereby guarantee payments of all charges incurred for the amount of this patient including transportation and care at any hospital or other facility by a physician and assign any benefits for that patient to BEAUFORT-JASPER-HAMPTON COMPREHENSIVE HEALTH SERVICES, INC.

I hereby authorize BEAUFORT-JASPER-HAMPTON COMPREHENSIVE HEALTH SERVICES, INC., to furnish from its records any information requested by insurance of liable third parties in connection with the above assignments.

Signature: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other _____

MEDICARE RELEASE/ASSIGNMENT

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers, or any additional third party responsible for payments of benefits, any information needed for this or any Medicare claim. I request that payment of authorized benefits be made in my behalf.

I assign payment for the unpaid charges for clinic and hospital physicians visits by physicians for whom BEAUFORT-JASPER-HAMPTON COMPREHENSIVE HEALTH SERVICES, INC., is authorized to bill. I understand that I am responsible for any insurance deductible and co-insurance.

Signature: _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other _____

Please Answer The Following Questions

1. Do you have Advance Directives? ☐ Yes ☐ No
2. Did you receive a Notice of Privacy? ☐ Yes ☐ No
3. Did you receive your Patient's Rights and Responsibilities? ☐ Yes ☐ No

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date