

**DeKALB COUNTY BOARD OF HEALTH**  
**INFORMATION ON PERSON TO RECEIVE SERVICES**  
**(INFORMACION DE LA PERSONA QUE VA A RECIBIR SERVICIOS)**

COUNTY No. \_\_\_\_\_ CLINIC No. \_\_\_\_\_ DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ SS#: \_\_\_\_\_ (NOMBRE) LAST  
 (APELLIDO) FIRST (NOMBRE) MIDDLE (APELLIDO DE SOLTERA)

LAST NAME AT BIRTH: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ AGE \_\_\_\_\_  
 (APPELLIDO AL NACER) (FECHA DE NACIMIENTO) (EDAD)

ADDRESS: \_\_\_\_\_  
 (DIRECCION): NUMBER (NUMERO) STREET (CALLE) APT. NO.

CITY: \_\_\_\_\_ COUNTY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 (CIUDAD) (CONDADO) (ESTADO) (CODIGO)

TELEPHONE: HOME: ( ) WORK: ( )  
 (TELEFONO: HOGER) (TRABAJO)

ETHNICITY: HISPANIC/LATINO \_\_\_ YES \_\_\_ NO EDUCATION : LEVEL COMPLETED \_\_\_\_\_

RACE: \_\_\_ BLACK (B)/AFRICAN AMERICAN \_\_\_ WHITE (W) \_\_\_ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER  
 (RAZA) \_\_\_ ASIAN (A) \_\_\_ MULTI-RACIAL (M) \_\_\_ AMERICAN INDIAN/ALASKA NATIVE (I)

MARITAL STATUS: \_\_\_ MARRIED (M) \_\_\_ SINGLES (S) \_\_\_ DIVORCED (D) \_\_\_ WIDOWED (W) \_\_\_ SEPARATED (S) \_\_\_  
 (ESTADO CIVIL) (CASADO) (SOLTERO) (DIVORCIADO) (VIUDO) (SEPARADO)  
 \_\_\_ UNKNOWN \_\_\_ NEVER MARRIED

SEX: \_\_\_ MALE \_\_\_ FEMALE PATIENT STATUS: \_\_\_ REVISIT/ESTABLISHED  
 (SEXO) (MASCULINO) (FEMENINA)

NUMBER IN FAMILY \_\_\_ GROSS MONTHLY INCOME \_\_\_\_\_ LIMITED ENGLISH PROFICIENCY (LEP) \_\_\_ YES \_\_\_ NO

INSURANCE STATUS:  
 PRIVATE: \_\_\_ ALL OR SOME FP SERVICES \_\_\_ NO FP SERVICES \_\_\_ UNKNOWN SERVICES  
 PUBLIC: \_\_\_ UNKNOWN \_\_\_ UNINSURED

PARENT'S NAME: \_\_\_\_\_  
 (NOMBRE DE LOS PADRES)

NEXT OF KIN/EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
 EN CASO DE EMERGENCIA CONTACTAR A PARENTEZCO

PHONE NUMBER: \_\_\_\_\_  
 (TELEFONO)

MEDICAID # \_\_\_\_\_ PEACHCARE # \_\_\_\_\_

MEDICARE # \_\_\_\_\_ MEDICARE PART B # \_\_\_\_\_

**I REQUEST SERVICES FOR THE PERSON NAMED: AUTHORIZED SIGNATURE**

**CONSENT FOR RELEASE OF IMMUNIZATION INFORMATION INTO THE GEORGIA IMMUNIZATION REGISTRY (GRITS):**

The DCBOH is authorized to release any immunization information and /or immunization documents containing such information to the GRITS database.

1. I, \_\_\_\_\_ agree to have immunization information released by the DCBOH into GRITS for the patient named above.

2. I, \_\_\_\_\_ decline to release immunization information to GRITS.

Central Health Center 440 Winn Way Decatur, Georgia 30030	Clifton Springs Health Center 3110 Clifton Springs Rd Decatur, Georgia, 30034	County Wide Health Center 445 Winn Way Decatur, Georgia 30030	East DeKalb Health Center 2277 S. Stn Mtn. Lithonia Rd Lithonia Georgia 30058	Kirkwood Health Center 30 Warren Street S.E. Atlanta, Georgia 30317	North Health Center 3807 Clairmont Rd N.E. Chamblee, Georgia 30341
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