DeKalb County Board of Health
Confidential Registration & Consent Form

Date of Service________________

Patient #____________________

(Please Print)

Patient's Name ____________________________ Birth Date _________________ Age __________

Maiden Name (if different) __________________

Address __________________ _________________________ _____________________

House Number | Street Name | Apartment Number

________________________ ____________ ____________ ________________

City | State | Zip Code | County

May we contact you by mail? ❒ Yes ❒ No

Home Phone ______________ Work Phone____________ Emergency Contact Number__________

Social Security Number ___________________________

Race ❒ White (W) ❒ Hispanic White (Z) ❒ Asian (A) ❒Other (O)

❒ Black (B) ❒ Hispanic Black (X) ❒ American Indian (I)

Sex ❒ Female (F) ❒ Male (M)

Marital Status ❒ Single ❒ Married ❒ Divorce ❒ Widowed

Education K-5 6-8 9 10 11 12 College 1 2 3 4 Graduate 1 2 3 4

Is the person listed above on **MEDICAID** or **RIGHT FROM THE START MEDICAID**? ❒Yes ❒ No
If Yes, Please show the clerk your current **MEDICAID** card when you complete this form.

Consent:

The undersigned patient and/or legal representative hereby authorizes the Health Center to administer and perform procedures, including emergency treatment or services which may include but are not limited to laboratory tests, x-ray examinations, and medical or minor surgical treatment or procedures which may now or during the course of the patient's care be deemed advisable or necessary by the provider. A copy of this signature is as valid as the original.

_________________________________ _________________________________

Printed Name of Patient, Parent or Legal Guardian | Signature of Patient, Parent or Legal Guardian

_________________________________ _________________________________

Witness | Date