Health Fair Pre-registration

This form is to register for our Health Fair to be held Oct. 20, 2018.

Please Print clearly and Complete the following information. This form should take 4 or 5 minutes to complete.

* **Patient Full Legal Name** First Name, Middle Initial, Last Name	
* **Primary Physician**	
* **Today's Date**	
* **Street Address** Full Street Address or P.O. Box	
* **City**	
* **County**	
* **State**	
* **Zip Code**	
* **Telephone** Area Code and 7 Digit Number	
Email Address Providing an email address will allow our Electronic Health Record System to set up a Patient Portal for you to use to access your test results electronically.	
* **Date of Birth**	
* **Marital Status**	○ Single ○ Married ○ Divorced
* **Sex**	○ Male ○ Female
* **Race**	○ Black ○ White ○ Asian ○ Indian
* **Social Security Number** Nine Digit Social Security Number	
* **Religion**	
Church Preference	
* **Are You Employed?**	○ Yes ○ No
Employer's Name If you are employed please list your major employer's business name.	

City	
State	
Zip Code Five Digit Zip Code	
Employer Phone Number Area Code Plus 7 Digit Number	
Occupation	
Test Selection Please indicate which test selections you desire	☐ Lipid Profile/CMP/CBC/TSH $30 ☐ PSA (Prostate Specific Antigen $10 ☐ Hemoglobin A1c $10 ☐ Vitamin D $35
* **Treatment Authorization for Cloud County Health Center County Health Fair 2018** I authorize representatives of Cloud County Health Center to draw blood and perform the procedures I have requested on this form. I understand that I have the option of receiving the test results or having them sent to my physician. I acknowledge that no guarantees have been made to me of care, treatment, or provision of medical services. I understand that I am responsible for full payment for the services provided at this time and that Cloud County Health Center will not bill it to my insurance company. I certify that I have read and fully understand and agree with its terms and statements.	☐
Results to be mailed to self Please select if you wish your results to be mailed to you.	☐
Results to be mailed to physician If you wish for your results to be mailed to your physician, please provide mailing address.	

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Patient/Responsible Party Signature **Date**

Please return completed Pre Registration form to the admissions desk at Cloud County Health Center or mail to:

CCHC
Attn: Registration
1100 Highland Drive
Concordia, KS 66901