PATIENT INFORMATION   Appointment Date: _____/______/_______

Patient's Legal Name *(Last, First, Middle)*:				Preferred Name:
Social Security Number:	Date of Birth:	Sex: ☐ M ☐ F	Home Phone:	Cell Phone:

Race (***Please choose one***):
☐ African American ☐ Caucasian ☐ Asian ☐ Other: ______________________________________

Ethnicity (***Please choose one***):
☐ Hispanic ☐ Non-Hispanic

Who do you live with:
☐ Mother ☐ Father ☐ Grandparent ☐Guardian: ____

Relationship to patient:

Street Address*(Required)*:	City:	State:	Zip Code:

Are you in DSS Custody? ☐ Yes ☐ No If yes, what county? ____

Mother/Guardian's Name:	**Father/Guardian's Name:**
Date of Birth: / Sex: ☐ M ☐ F / SSN:	Date of Birth: / Sex: ☐ M ☐ F / SSN:
Street Address *(Required if different from above)*:	Street Address *(Required if different from above)*:
City: / State: / Zip Code:	City: / State: / Zip Code:
Home Phone: / Cell Phone: / Work Phone:	Home Phone: / Cell Phone: / Work Phone:
Email:	Email:

May we leave a message at: ☐ Home ☐ Cell ☐ Work

Emergency Contact:	Relationship to Patient:	Phone Number:	Alternative Number:

INSURANCE INFORMATION:

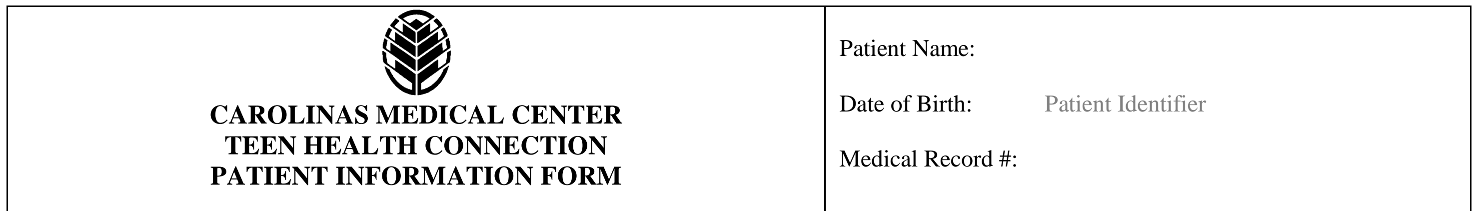
☐ PRIVATE ☐MEDICAID ☐SLIDING SCALE ☐SELF-PAY

PRIMARY	**SECONDARY**
Name of Plan:	Name of Plan:
Policy Number: / Group Number:	Policy Number: / Group Number:
Policy Phone Number:	Policy Phone Number:
Type of Plan: ☐ PPO ☐ HMO ☐ POS ☐Other: _______________	Type of Plan: ☐ PPO ☐ HMO ☐ POS ☐Other: ______________
Policy Holder's Name:	Policy Holder's Name:
SSN: / Date of Birth:	SSN: / Date of Birth:
Employer's Name:	Employer's Name:

Did someone refer you to our facility? ☐ Yes ☐ No

If yes, please write who referred you:

How did you hear about Teen Health Connection:
☐ Relative ☐ Friend ☐ Internet ☐ Other: _________________________________



CAROLINAS MEDICAL CENTER
TEEN HEALTH CONNECTION
PATIENT INFORMATION FORM

Patient Name:

Date of Birth: Patient Identifier

Medical Record #: