Fetter Health Care NETWORK

51 Nassau Street
Charleston, SC 29403
Phone (843) 722-4112
Fax (866) 285-7156

PATIENT DEMOGRAPHICS

Last Name: ____________________ First Name: ____________________ Middle: ____________

Social Security Number: ________ - ________ - ________ Date of Birth: __________ Sex: □ Female □ Male

Home Address: ____________________ City __________ State __________ Zip: __________

Mailing Address: ____________________ City: __________ State __________ Zip: __________

Home Phone ____________ **Work Phone** ____________ **Cell Phone:** ____________ Email: ____________

Emergency Contact: ____________________ **Relationship**: ____________ Phone: ____________

Marital Status: □ SINGLE □ MARRIED □ DIVORCED □ SEPARATED □ WIDOW(ER)

Race □ WHITE □ Black □ ASIAN □ Native Hawaiian □ PACIFIC □ Other □ AMERICAN INDIAN OR ALASKA NATIVE

Ethnicity: □ LATINO □ HISPANIC □ OTHER

Veteran: □ YES □ NO

Gender Identity □ Male □ Female □ Female to Male □ Male to Female □ Gender Queer □ Other □ Declined

Sexual Orientation □ Lesbian, Gay or Bi-sexual □ Straight or Heterosexual □ Bisexual □ Something Else □ Don't Know □ Declined

LIVING/MIGRANT STATUS

Living Status: □ RENT □ OWN □ TEMPORARY If Temporary □ SHELTER □ FAMILY OR FRIENDS □ ASSISTANT LIVING

Migrant Status

	Yes	**No**
Have any member(s) of your family worked in agriculture (i.e. field, packing shed?	□ Seasonal Migrant	□ Ineligible
Are you a resident of the County in which you live?	□ Seasonal	□ Migrant
Are you planning to stay and live in that County?	□ Seasonal	□ Migrant
Did you come to this area to do farm work?	□ Migrant	□ Ineligible
Will you leave this area to follow farm work?	□ Migrant	□ Ineligible

Local Camp/Residence Crew Leader/Growers

What is your household size? ____________ **# of children** ______ **# of Adults** ______

What is your household income? ____________ **weekly**_____ **monthly**______ **yearly** ______

PARENT/GUARDIAN'S INFORMATION (RESPONSIBLE PARTY)

Last Name: ____________________ **First Name:** **Middle:**

Social Security Number: ______ - - ______ **Date of Birth:** **Sex:** □ Female □ Male

Home Address: ____________________ **City** **State** **Zip**:

Home Phone: ____________ **Work Phone** ____________ **Cell Phone:** ____________ **Relationship:** ____________

INSURANCE INFORMATION

Company Name ____________________

Policy Number: ____________ **Group Number:** ____________ **Co-Pay:** $ ________

2nd Company Name: ____________________

Policy Number ____________ **Group Number:** ____________ **Co-Pay:** $ ________

□ **SLIDING FEE APPLICATION ATTACHED**

I, the undersigned certify that the information on this Enrollment Form is given to the best of my knowledge. I understand I am responsible for presenting my Insurance Card at each visit and I am financially responsible for services not paid by my Insurance Company. I further understand that any Nominal Fee, Sliding Fee, or Co-Payment required be paid on the dates services are rendered. I authorize Fetter Health Care Network to release any medial information that may be needed for billing, consultation, or referral purposes for my dependent(s) or me. Fetter Health Care Network reserves the right to verify Medicaid/Medicare insurance coverage for all patients and apply charges appropriately.

□ **Privacy Notice Issued**

Patient (Parent/Guardian) Name: ____________________ **Date:** ____________

Medical Services Staff: ____________________ **Date:** ____________