Sherman County Health Department
Client Registration and Health History Form

Name:	Date Form Completed:
DOB: Age:	◻ Female ◻ Male
◻ Married ◻ Single ◻ Divorced ◻ Widowed	Name of Spouse:
Home Address: City:	Zip:
Phone: (Home) (Cell)	(Work)
Emergency Contact Person: (Phone)	
**** Can we contact you at the phone numbers and address above?**	**◻ Yes ◻ No**
May we e-mail our monthly Newsletter to you? ◻ Yes ◻ No E-Mail address:	
If a minor child, Name of Responsible Party: Address of Responsible party (if different than above):	
Insurance: ◻ None ◻ BC/BS ◻ Other Private Insurance ◻ Medicare ◻ Medicaid ◻ KanCare Name of Insured: DOB Policy # Name of Insured: DOB Policy #	
Ethnicity: ◻ Not Hispanic/Latino ◻ Hispanic/Latino (if Hispanic, check below) ◻ Mexican ◻ Cuban ◻ Puerto Rican ◻ Central/South American ◻ Other/Unknown)	
Race: (Mark all that apply) ◻ White ◻ Black/African American ◻ American Indian/Alaskan Native ◻ Asian ◻ Unknown/Not Reported ◻ Native Hawaiian/Pacific Islander	
Insurance: I authorize payment of medical benefits to be made directly to Sherman County Health Department for services rendered. I authorize any insurance company, organization, employer, hospital, physician, pharmacist, health department to release any information to this claim and the expenses reported.	
Signature:	**Date:**
Authorization: I give my permission for the Sherman County Health Department to provide screening, testing, health assessment or treatment for myself or my child, _____. I have been informed of the procedure and my questions have been answered satisfactorily.	
Signature:	**Date:**
I acknowledge that I have been provided the Health Department's Notice of Privacy Practices with the effective date of August 30, 2013.	
Signature:	Date:

Significant Health History:
Allergies:
Medication:
Hospitalization:
Surgeries (Major):

Revised 2/13/2015