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|  | **CoxHealth**Regional Services**C.A.R.E. MOBILE REGISTRATION** | Name: Age: DOB: \_\_\_/\_\_\_/\_\_\_\_\_\_SSN or ID: (or Patient Sticker Here) |

Child’s Legal Name: SSN#: Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_

Sex: Male Female Address: \_ City: State \_\_\_\_\_ Zip:

School: Primary Language: English Spanish Other:

**FINANCIAL OBLIGATION\***

*\* The mission of the C.A.R.E. Mobile program is to provide access to health care for children in the Ozarks who have no insurance, do not have a primary care physician or whose parents cannot afford to pay for necessary services. However, no child will be turned away.*

**STUDENT QUALIFIES FOR FREE OR REDUCED LUNCH? Yes No NO INSURANCE** (SELF PAY)

**PRIMARY INS: POLICY HOLDER NAME:**

Policy Holder’s Employer: Policy Holder SSN#:

Group #: Policy/ID #: Policy Holder DOB: \_\_\_/\_\_\_/\_\_\_\_\_\_

Patient’s Relationship to Policy Holder: Child Other (explain)

**PARENT OR GUARDIAN and EMERGENCY CONTACT INFORMATION**

Emergency Contact: Phone: Relationship:

RELATIONSHIP: Father Mother Guardian

Name: (First, MI, Last) SSN#: Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_

Address: City/State/Zip: Home Phone:

Employer: Work Phone: Mobile Phone:

Preferred method of contact? Email Home Phone Letter Mobile Phone Work Phone

RELATIONSHIP: Father Mother Guardian

Name: (First, MI, Last) SSN#: Date of Birth: \_\_\_/\_\_\_/\_\_\_\_\_\_

Address: City/State/Zip: Home Phone:

Employer: Work Phone: Mobile Phone:

Preferred method of contact? Email Home Phone Letter Mobile Phone Work Phone

**FAMILY HISTORY**

Ethnicity: Hispanic or Latino American Indian or Alaska Native Asian Black or African American White Native Hawaiian or Other Pacific Islander

Patient’s biological family has a history of:



Stroke Heart disease or heart attack Diabetes/sugar disease High blood pressure







High cholesterol Diabetes/sugar disease Asthma Hearing loss at young age

Vision loss at young age Alzheimer’s disease/dementia Developmental delay/retardation Miscarriage/stillbirth

Breast cancer Ovarian cancer Endometrial (uterine) cancer Colon cancer

Birth Defects Genetic conditions:

Other Cancer(s):

Genetic Conditions:

Mental Health:

Other Health Concerns:

Identify family members with each condition checked:

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| --- | --- | --- | --- | --- |
| Relationship | Condition | Age of Onset | Current Age | Age and Cause of Death |
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|   |   |   |   |   |
| *Example: Grandmother on Fathers ’ Side* | *High Blood Pressure* | *61* |   | *87, Stroke* |

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