



**CoxHealth**  
Regional Services  
**C.A.R.E. MOBILE REGISTRATION**

Name: \_\_\_\_\_  
Age: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
SSN or ID: \_\_\_\_\_  
(or Patient Sticker Here)

\*CONSNT\*

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) \_\_\_\_\_

**SECONDARY 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:

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Heart disease or heart attack | <input type="checkbox"/> Diabetes/sugar disease          | <input type="checkbox"/> High blood pressure       |
| <input type="checkbox"/> High cholesterol         | <input type="checkbox"/> Diabetes/sugar disease        | <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Hearing loss at young age |
| <input type="checkbox"/> Vision loss at young age | <input type="checkbox"/> Alzheimer's disease/dementia  | <input type="checkbox"/> Developmental delay/retardation | <input type="checkbox"/> Miscarriage/stillbirth    |
| <input type="checkbox"/> Breast cancer            | <input type="checkbox"/> Ovarian cancer                | <input type="checkbox"/> Endometrial (uterine) cancer    | <input type="checkbox"/> Colon cancer              |
| <input type="checkbox"/> Birth Defects            | <input type="checkbox"/> Genetic conditions: _____     |  |  |

Other Cancer(s): \_\_\_\_\_

Genetic Conditions: \_\_\_\_\_

Mental Health: \_\_\_\_\_

Other Health Concerns: \_\_\_\_\_

Identify family members with each condition checked:

Relationship	Condition	Age of Onset	Current Age	Age and Cause of Death
<i>Example: Grandmother on Father's Side</i>	<i>High Blood Pressure</i>	<i>61</i>		<i>87, Stroke</i>

**CONTINUED ON BACK**



\*CONSNT\*

CoxHealth Regional Services C.A.R.E. MOBILE REGISTRATION

Name: Age: DOB: SSN or ID: (or Patient Sticker Here)

CONTINUED FROM FRONT

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES

For parents/guardians - (Only complete this section if your child is being vaccinated by the C.A.R.E. Mobile): The following questions will help us determine which vaccines your child may be given...

- 1. Is the child sick today? 2. Does the child have allergies to medications, food, a vaccine component, or latex? 3. Has the child had a serious reaction to a vaccine in the past? ... 10. Has the child received vaccinations in the past 4 weeks?

Please send your child's immunization record card with them on the day of their visit to the C.A.R.E Mobile.

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it.

Parent Signature

Date

VACCINE RECORD (FOR C.A.R.E. MOBILE USE ONLY)

Vaccines for Children (VFC) Program Eligibility Status: Medicaid No health insurance American Indian/Alaska Native Underinsured (FQHC/RHC) Diphtheria, Tetanus NOT VFC Eligible

Table with 10 columns: Vaccine, Route, M/D/Y Given, Injection Site, Manufacturer, Lot Number, Exp. Date, NDC Number, VIS Rev. Date, Date VIS Given. Includes an example row for Hib vaccine.

Comments:

Vaccinator Signature CPS-3028.12 01-18 Rev.04-18

Vaccinator Title

Date