CABELL-HUNTINGTON HEALTH DEPARTMENT
BASIC DATA INFORMATION SHEET

New ____ Return ____ Date Last Seen _____

Name:	**Telephone:**
DOB: **Age:**	**Sex:** **Male** **Female** **Other**
Social Security Number:	**Last Grade of School Completed:**
Address:	**City / State / Zip:**
County:	**Race:**
Hispanic / Latino **Not Hispanic / Latino**	**Marital Status:** **S** **M** **W** **D** **Other**
Number of People in Home:	**Monthly Income (Household):**
Place of Employment:	**Paid** **Weekly** **Bi-Monthly** **Monthly**
Employer Phone:	**Insurance Name:**
Employer Address:	
You should know that insurance companies send out a letter called an Explanation of Benefits (EOB) to insurance policy holders about health care services you receive at the clinic.	
Preferred Method of Contact (Must provide two): **Phone** **Mail** **Text** **E-Mail**	
E-Mail Address:	
Alternate Contact Name:	**Relationship:**
Address:	**Phone:**
Preferred Language:	**Do you need an Interpreter?** **Y** **N**
_____ Do Not Contact Directly (MUST PROVIDE ALTERNATE CONTACT ABOVE)	
I allow CHHD to leave confidential voicemails, emails or text at all forms of information provided above. Y N	
If you test positive for any test you have today, you *WILL* be contacted by CHHD staff or by an employee with the State of WV and notified of your test results.	

Please read and answer the following:

Yes / No **I verify that the above information is correct and that I can be reached by at least two methods listed above. I will notify Cabell-Huntington Health Department if my information changes.**

Yes / No **I understand that I MUST return to the Health Department in 2 to 3 weeks to pick up test results.**
(*Pap results will be mailed approximately 4 weeks after appointment date)*

Yes / No **I understand a Photo ID is required to pick up results.**

Yes / No **I understand that if I am unable to produce a photo ID I will be given an identification number that I must present when picking up test results.**

Consent For Services – Assurance of Confidentiality and Provided on a Confidential and Non-Discriminatory Basis

- **I understand medical services may include appropriate laboratory testing, physical examination, pap smear and pelvic examination.**
- **I voluntarily agree to participate in the Family Planning Program and grant permission to have such physical examination, diagnostic and/or treatment procedures as may be deemed necessary in collaboration with authorized personnel of said health facility.**
- **I have been informed that this clinic assures patient confidentiality and provides safeguards against the invasion of personal privacy, as required by the Privacy Act of 1974 and Health Information, Portability and Accountability Act (HIPAA) regulations. All information which may be identified with me will be considered privileged and confidentiality will be maintained.**

_____ _____ _____

Client Signature **Date** **Witness**