PIEDMONT HEALTH SERVICES

"People Caring for People for Over 45 Years"

Chambers Program Registration Form *(Please Print)*

Medical ☐ **Dental** ☐ **Medical & Dental** ☐

Name: Click here to enter name
Responsible Party: Click to enter (if under 18) **Relationship to Patient**: Click to enter
Number of Dependents: Click here to enter
Address: Click here to enter address
City/State/Zip: Click here to enter City/State/Zip

Best Phone number to reach you: Click enter phone **2nd Phone:** Click enter phone
Date of Birth: Click here to enter date. **Sex:** Male ☐ Female ☐

Race: White/Caucasian ☐ Black/African American ☐ Asian ☐ Multi-racial ☐
American Indian ☐ Other ☐ **Hispanic:** Yes ☐ No ☐

Circle appropriate program name:

Associations:	**Chamber of Commerces:**	
OCHAR	Alamance	Chatham
	Caswell County	Hilllsborough-Orange County
	Chapel Hill- Carrboro	Roxboro Area

Business /Employer: Click here to enter text.
Employed Since: Click to enter date **Job/Occupation:** Click to enter job title
Email: Click here to enter text. **Military Veteran:** Yes ☐ No ☐
Health Center where you want to receive care: Click here to enter what location
Emergency Contact: Name: Click here to enter emergency contact
Phone: Click here to enter phone **Relationship:** Click here to enter text.

****Please bring photo identification when visiting any of our 8 community health centers****

TREATMENT/OPERATION/PAYMENT AGREEMENT WITH PIEDMONT HEALTH SERVICES, INC.

I authorize PIEDMONT HEALTH SERVICES to provide me and/or my family with medical/dental care. I authorize assignments of insurance benefits for medical/dental care to be paid to PIEDMONT HEALTH SERVICES. I authorize the use or disclosure of protected health information belonging to myself and/or family members for the purposes of treatment and operations. I understand that it is my responsibility to pay for the medical/dental care provided by PIEDMONT HEALTH SERVICES. **I have reviewed the Notice of Information Privacy Practices and have been offered a copy of it.** I have been given an opportunity to ask questions about the Privacy Policy and the protection of my confidential health information at PIEDMONT HEALTH SERVICES. I also attest that all of the information I have provided is correct.

Signature: Click here to enter signature Date: Click here to enter date
(Patient or responsible party if under 18)

Return by fax: (919) 933-9201, email rixa@piedmonthealth.org or mail to Amy Rix at 127 Kingston Drive, Chapel Hill, NC 27514.

Visit our website: www.piedmonthealth.org