Beaufort County Health Department
Client Registration and Financial Information

First Name: _____ **Middle:** _____ **Last Name:** _____

Maiden or Other Name Used: _____ ☐ Female ☐ Male

Date of Birth: _____ **Social Security #:** _____

Mailing Address (including City, State, and Zip Code):

_____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Can we contact you by mail? ☐ Yes ☐ No - If no, can we send a plain envelope with no return address? ☐ Yes ☐ No

Can we contact you by telephone? ☐ Yes ☐ No

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Race: ☐ White ☐ Hispanic ☐ Native American ☐ Asian ☐ African American

Please list family members who live in your household and their income. Eligibility is good for one year unless there is a change in the income listed below.

Name	Relation to Patient	Income Earned
	Self	

Family Size	Total Income

☐ Proof of Income

☐ Self-Declaration

For Children Receiving Immunization Services:

Parent/Guardian's Name: _____
Parent/Guardian's Social Security #: _____

My signature below indicates to the best of my knowledge this income is true and correct. Proof of income is requested within 14 days of service to determine sliding fee scale eligibility.

Client Signature: _____ **Date:** _____

Witness: _____ **Date:** _____