700 EAST OAK STREET
CANTON ILLINOIS 61520
Phone: 309-647-1134
Fax: 309-647-9545
Contact Us On The Web At:
**www.fultoncountyhealth.com**

Astoria Sub-office
309-329-2922

Cuba Sub-Office
309-785-5300

# FULTON COUNTY HEALTH DEPARTMENT

An Equal Opportunity Employer and Provider

## PATIENT REGISTRATION

First Name: _____ MI _____ Last Name: _____

Birthdate: _____ SEX _____ Age:_____ Home Phone: _____

Address: _____ CellPh: _____

City: _____ State: _____ Zip: _____

Medicaid Id#: _____ Other Insurance: _____

Pharmacy Name and Address: _____

Household Size: _____ Household Annual Income: _____
(determines fee scale for pay clients)

**IMPORTANT: PROOF OF INCOME OR CURRENT MEDICAID/ALLKIDS CARD MUST BE PRESENTED AT EACH APPOINTMENT.**

## RECEIPT OF NOTICE OF PRIVACE PRACTICES

I, (patient name) _____, hereby acknowledge that I received the "Notice of Privacy Practices" from the Fulton County Health Department dated Sept. 10, 2013. I understand that the health department is already authorized to use the information gained to bill me, my insurance company, or any other potential sources of reimbursement, such as government programs in which I am enrolled or qualify for services. I also agree to allow release of treatment and/or appointment information to my child's school if necessary.

_____ (Initial) I have received a copy of Patient Responsibility Flyer and have read and understood it.

_____ _____
DATE SIGNATURE

_____

FCHD: 10/13