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

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

Child's Legal Name: _____ SSN#:_____ Birth Date: _____/_____/_____
Sex: Male Female Address: _ _____ City: _____ State _____ Zip: _____
School: Jarrett STEAM Academy 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) _____

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:

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

☐ 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
Example: Grandmother on Fathers' Side	*High Blood Pressure*	*61*		*87, Stroke*

Parent/Guardian Signature: _____ Date: _____