Bertie County Rural Health Association
P.O. Box 628, 104 Rhodes Avenue
Windsor, NC 27983
Phone (252) 794-3042 Fax (252) 794-291

Patient Information:

_____ _____ _____ _____
Last Name First Name Middle Int. SS#
Physical Address:_____ _____ _____ _____
Street / PO Box City State Zip Code
Mailing Address: _____ _____ _____ _____
Street / PO Box City State Zip Code
Home Phone: _____ Work/ Cell/ Other Phone: _____
Email:_____ DOB_____ Sex: M or F Marital Status: MSDW Separated
Race: White Black/African American American Indian/Alaska Native Hispanic/Latino Asian Native Hawaiian Two or More Races Others_____

(Please Circle one)
Sexual Orientation: Lesbian/Gay Straight (not lesbian/ gay) Bisexual Something Else Don' Know Choose not to disclose
(Please circle one)
Gender Identity: Male Female Transgender Male/ Female-to Male Transgender Female/ Male-to Female Other Choose not to disclose
ETHNICITY:_____ Veteran: Yes or No
Employer:_____ Phone Number:_____
Education Level:_____ Highest Grade Completed:_____
Emergency Contact: Primary Caregiver:_____
Name:_____ Relationship To Patient: _____
Home Phone: _____ Work/Cell/Other Phone: _____
_____ _____ _____ _____
Street/PO Box City State Zip Code
Responsible Party Information: Legal Guardian/Health Care Proxy: _____
Name:_____ Relationship To Patient_____
Home Phone:_____ Work/Cell/Other Phone:_____
Mailing Address:_____ _____ _____ _____
Street/PO Box City State Zip Code
Insurance Information:
Name of Insurance Company: _____
Name of Policy Holder: _____
Policy Holder's SS No:_____ DOB:_____
Policy Holder's Employer_____ Phone #: _____
Relationship of Policy Holder to Patient_____

I hereby give Windsor Community Health Center (BCRHA) permission to treat me. I also give them permission to file my insurance for payment of medical benefit and supplies for services rendered. Furthermore, I authorize Windsor Community Health Center to release pertinent information to my insurance company and other medical facilities involved in my care.

Signature:_____ Date:_____

BERTIE COUNTY RURAL HEALTH ASSOCIATION
ANNUAL PATIENT INFORMATION UPDATE
January-December_____

PATIENT NAME: _____ DOB: _____

PHONE#: _____ CELL/WORK#: _____

EMERGENCY CONTACT: _____
RELATIONSHIP TO EMERGENCY CONTACT: _____

HEALTH INSURANCE: _____ VETERAN: YES or NO (Circle One)

YEARLY HOUSEHOLD ESTIMATE

BERTIE COUNTY RURAL HEALTH ASSOCIATION IS REQUIRED TO REPORT INCOME DATA ON OUR PATIENTS IN ORDER TO RECEIVE FEDERAL FUNDING TO SERVE THE UNINSURED. THIS INFORMATION IS CONFIDENTIAL. REPORTING IS AGGRAGATE AND NOT PATIENT SPECEIFIC.

YEARLY HOUSEHOLD ESTIMATE
PLEASE CIRCLE INCOME AND FAMILY SIZE

Size of Family Unit	Income	Income	Income	Income	Income
1	0-12,060	12,061-15,075	15,076-18,090	18,091-21,105	21,106-24,120
2	0-16,240	16,241-20,300	20,301-24,360	24,361-28,420	28,421-32,480
3	0-20,420	20,421-25,525	25,526-30,630	30,631-35,755	35,756-40,840
4	0-24,600	24,601-30,750	30,751-36,900	36,901-43,050	43,051-49,200
5	0-28,780	28,781-35975	35,976-43,170	43,171-50,365	50,366-57,560
6	0-32,960	32,961-41,200	41,201-49,440	49,441-57,680	57,681-65,920
7	0-37,140	37,141-46,425	46,426-55,710	55,711-64,995	64,996-74,280
8	0-41,320	41,321-51,650	51,651-61,980	61,981-72,310	72,311-82,640

_____ _____
PATIENT SIGNATURE DATE

_____ _____
PATIENT CARE REPRESENTATIVE DATE