



**PIEDMONT HEALTH SERVICES**  
*“People Caring for People for Over 45 Years”*



**Chambers Program Registration Form (Please Print)**

**Medical**

**Dental**

**Medical & Dental**

**Name:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_  
(If under 18)

**Number of Dependents:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City/State/Zip:** \_\_\_\_\_

**Best Phone number to reach you:** \_\_\_\_\_ **2<sup>nd</sup> Phone:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** Male  Female

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

**Click to check appropriate program name:**

<b>Associations:</b>	<b>Chamber of Commerces:</b>	
OCHAR	Alamance	Chatham
	Caswell County	Hillsborough-Orange County
	Chapel Hill- Carrboro	Roxboro Area

**OCHAR / Chamber Employer:** \_\_\_\_\_

**Employed Since:** \_\_\_\_\_ **Job/Occupation:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Military Veteran:** Yes  No

**Health Center where you want to receive care:** \_\_\_\_\_

**Emergency Contact: Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

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

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

I attest that all of the information I have provided is correct and 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 will receive the Notice of Information Privacy Practices Act when I make my first visit.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Patient or responsible party if under 18)

**Return by fax: (919) 933-9201, email [rix@piedmonthhealth.org](mailto:rix@piedmonthhealth.org) or mail to Amy Rix at 127 Kingston Drive, Chapel Hill, NC 27514.**

**Visit our website: [www.piedmonthhealth.org](http://www.piedmonthhealth.org)**