JACKSON COUNTY DEPARTMENT OF PUBLIC HEALTH
Master Sheet

Today's Date__________________ Reason for today's visit: ______________________________

Legal Name ____
(First) (Middle) (Last)

Mailing Address: ____

____
City State Zip

Physical Address: ____

____
City State Zip

Is it okay to receive mail at the address mentioned above? ________ Yes ________ No

County of Residence: _______________ Home Phone_______________ Cell Phone____________

Date of Birth: ________________ Sex: ______ M ______ F

Race: ____________ Ethnic Origin: ________________ Preferred Language: ________________

Do you have Medicaid or Insurance ________ Yes ________ No

We can bill private insurance for some services, please provide your insurance information below so we can accurately bill:

Insured's Name as it appears on card

____

Insured's ID # __________________________ Insured's Date of birth _______________________
(Please have card ready to copy)

To update Immunizations please provide the following.
(The state of North Carolina has an electronic data base of all immunizations. It is important to provide mothers information to ensure that data is correctly entered into your record)

____
Mother's Last Name Mother's First Name Mother's Maiden Name

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