Mountain Health Center

# PATIENT REGISTRATION FORM

Mountain Health DENTAL CARE

☐ Medical ☐ Dental

## PATIENT INFORMATION

*PLEASE FILL OUT ENTIRE FORM IN BLUE OR BLACK PEN ONLY*

| LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|
| | | |

| STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| HOME PHONE | CELL PHONE | WORK PHONE | PRIMARY CARE PROVIDER | DATE OF BIRTH |
|---|---|---|---|---|
| | | | | |

**SEX AT BIRTH** ☐ Male ☐ Female

**MARITAL STATUS** ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Partner ☐ Widowed

**SOCIAL SECURITY NUMBER**

**EMPLOYER NAME** **EMPLOYER PHONE NUMBER**

**EMPLOYMENT STATUS** ☐ Full-Time ☐ Part-time ☐ Seasonal ☐ Student ☐ Self-Employed ☐ Not Employed

**EMERGENCY CONTACT NAME** **RELATIONSHIP TO PATIENT** **EMERGENCY CONTACT PHONE NUMBER**

**WOULD YOU LIKE ACCESS TO PATIENT PORTAL?** ☐ Yes ☐ No

**EMAIL ADDRESS**

**PHARMACY NAME & TOWN**

**PREFERRED CONTACT METHOD** ☐ HOME PH ☐ CELL PH ☐ TEXT MSG

**RACE** *(Check all that apply)* ☐ African-American ☐ Asian ☐ Native American/Alaska Native ☐ White ☐ Native Hawaiian ☐ Other Pacific Islander

**ETHNICITY** ☐ Non-Hispanic ☐ Hispanic

**AGRICULTURAL WORKER** ☐ Seasonal ☐ Migrant

**ARE YOU A U.S. VETERAN?** ☐ Yes ☐ No

**ARE YOU HOMELESS?** ☐ Yes ☐ No

**PRIMARY LANGUAGE IF NOT ENGLISH** _____

**DO YOU NEED TRANSLATION SERVICES?** ☐ Yes ☐ No

**GENDER**
- ☐ Male
- ☐ Female
- ☐ Transgender Male
- ☐ Transgender Female
- ☐ Other
- ☐ Do not wish to report

**SEXUAL ORIENTATION**
- ☐ Lesbian or Gay
- ☐ Straight/Heterosexual
- ☐ Bisexual
- ☐ Something Else
- ☐ Don't Know
- ☐ Do not wish to report

**FAMILY FINANCIAL INFORMATION**

Family/Household size: _____

Household Income: _____

☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Annually

**HOW DID YOU HEAR ABOUT US?**
- ☐ Current Patient
- ☐ Live Nearby/Locally
- ☐ Family/Friend
- ☐ Newspaper
- ☐ Online
- ☐ Other: _____ *(Please Specify)*

## RESPONSIBLE PARTY INFORMATION

*ANY PATIENT UNDER 18 MUST HAVE A RESPONSIBLE PARTY*

☐ **PATIENT** (18 Years or older) ☐ **CUSTODIAL PARENT** ☐ **GUARDIAN** (Proof of legal status required for treatment)

| LAST NAME | FIRST NAME | MIDDLE INITIAL |
|---|---|---|
| | | |

| STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

| DATE OF BIRTH | HOME PHONE |
|---|---|
| | |

## MEDICAL INSURANCE

☐ I currently have **MEDICAL** insurance (see below)

☐ I currently **DO NOT** have **MEDICAL** insurance

☐ I would like to apply for the **SLIDING-FEE SCALE DISCOUNT**

Medical Ins. Name: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

## DENTAL INSURANCE

☐ I currently have **DENTAL** insurance (see below)

☐ I currently **DO NOT** have **DENTAL** insurance

☐ I would like to apply for the **SLIDING-FEE SCALE DISCOUNT**

Dental Ins. Name: _____

Policy Number: _____

Group Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

☐ I have read the ***Notice of Privacy Practices*** for Mountain Health Center.

☐ I have ***declined*** to read the ***Notice of Privacy Practices*** for Mountain Health Center. I am aware that there is a copy posted in the office.

Signature of Patient or Guardian: _____ Printed Name: _____ Date: _____