PATIENT REGISTRATION FORM

☐ Medical ☐ Dental

PATIENT INFORMATION

PLEASE FILL OUT ENTIRE FORM IN BLUE OR BLACK PEN ONLY

LAST NAME | FIRST NAME | MIDDLE INITIAL

MAILING 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: ____________