Mountain Health Center

Patient Registration Form

PATIENT INFORMATION

PLEASE FILL OUT ENTIRE FORM IN BLUE OR BLACK PEN ONLY

LAST NAME	FIRST NAME	MIDDLE INITIAL	
911 ADDRESS	**CITY**	**STATE**	**ZIP**
MAILING ADDRESS	**CITY**	**STATE**	**ZIP**

HOME PHONE	CELL PHONE	WORK PHONE	DATE OF BIRTH	SOCIAL SECURITY #

SEX AT BIRTH
☐ Male ☐ Female

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

EMAIL ADDRESS

EMPLOYER NAME

EMPLOYER PHONE NUMBER

EMPLOYMENT STATUS
☐ Full Time ☐ Part Time ☐ Self Employed
☐ Seasonal ☐ Student ☐ Not Employed

EMERGENCY CONTACT NAME

RELATIONSHIP TO PATIENT

EMERGENCY CONTACT PHONE NUMBER

WOULD YOU LIKE PATIENT PORTAL ACCESS?

PHARMACY NAME & TOWN

PRIMARY CARE PROVIDER

PREFERRED CONTACT METHOD
☐ Home Phone ☐ Cell Phone
☐ Text Message

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

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
☐ Bisexual
☐ Lesbian or Gay
☐ Straight/Heterosexual
☐ 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**

Primary Insurance Name: _____
Policy Number: _____
Group Number: _____
Policy Holder's Name: _____
Policy Holder's Date of Birth: _____

Secondary Insurance 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*