MCHC HEALTH CENTERS

PATIENT REGISTRATION

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Preferred Pronouns (he, she, they): _____

Previous Last Name: _____ Sex at Birth: ☐ Male ☐ Female

Social Security #: _____ Date of Birth: _____

Mailing Address: _____ City: _____ St: ___ Zip: _____

Home Address (if different than mailing): _____ City: _____ St: ___ Zip: _____

Primary (Preferred) Language: ☐ English ☐ Spanish ☐ Other: _____

Marital Status**:** ☐ Married ☐ Single ☐ Single w/partner ☐ Divorced ☐ Separated ☐ Widow(er)

Medical Provider Name: _____

Please check preferred contact method:

Phone: ☐ Home _____ ☐ Work _____ ☐ Cell _____

Okay to leave a message? ☐Yes ☐ No If not, please provide alternative number: _____

☐ E-mail address: _____ ☐ No e-mail address

In case of emergency, please contact:

Name _____ Phone _____ Relationship _____

Additional Patient Information (please answer all questions): This required information is for demographic purposes only and will not affect your care.

Homeless: ☐ YES ☐ NO If Yes, fill out homeless status below:

Homeless Status (Please check one):

☐ Permanent Supportive Housing ☐ Motel/Hotel ☐ Housing Program
☐ Street/Campground ☐ Transitional Housing ☐ Shelter ☐ Doubling Up (Family or Friend)

Farmworker: ☐ YES ☐ NO If Yes: ☐ Migrant ☐ Seasonal

Veteran: ☐ YES ☐ NO

Race (Please check all that apply): ☐ White (inc. Hispanic/Latino) ☐ Black/African American
☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ Decline to specify

Ethnicity (Please check one): ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Decline to specify

Family Size: _____ **Household Income:** $_____ Annually

Sexual orientation and gender identity can play a significant role in determining health outcomes. Asking these questions also improves patient centered care. *Do you think of yourself as:*

Gender Identification (Please check one):

☐ Female ☐ Male ☐ Female to Male/Transgender ☐ Male to Female/Transgender
☐ Genderqueer ☐ Other ☐ Decline to specify

Sexual Orientation (Please check one):

☐ Straight/Heterosexual ☐ Gay, Lesbian, Homosexual ☐ Bisexual
☐ Don't Know ☐ Other ☐ Decline to specify

Primary Insurance:

☐ Medi-Cal ☐ Medicare ☐ Family Pact ☐ Partnership ☐ CMSP

☐ Any Other Coverage _____ (Blue Cross, Blue Shield, Delta, etc.)

ID/Subscriber #: _____ Plan/Group #: _____

Subscriber Name**:** _____ Date of Birth: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance:

☐ Medi-Cal ☐ Medicare ☐ Family Pact ☐ Partnership ☐ CMSP

☐ Any Other Coverage _____ (Blue Cross, Blue Shield, Delta, etc.)

ID/Subscriber #: _____ Plan/Group #: _____

Subscriber Name**:** _____ Date of Birth: _____

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If patient is a minor complete this section.

Responsible Party:

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to patient: _____ Phone: _____

Address (if different): _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Social Security Number: _____

Mother's/Guardian's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Father's/Guardian's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

CONDITIONS OF TREATMENT

FINANCIAL AGREEMENT: I agree to make prompt payments as bills are received for services rendered by Mendocino Community Health Clinic, Inc. I agree to pay interest at the legal rate if the account becomes delinquent, and if it becomes necessary for the account to be referred to collection, I will pay the attorney's fees and collection expenses.

If you are concerned about your ability to pay for your medical care please speak with our Financial Services Representatives.

MEDICARE ASSIGNMENT: I certify that the information given by me in applying for payment under Title VII of the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf.

ASSIGNMENT OF INSURANCE BENEFITS: In the event I am entitled to benefits from any insurance policy insuring me or any party liable to me, I assign those benefits directly to MCHC, Inc. for application to my bill. I agree that MCHC, Inc., may issue a receipt for such payment, that such payment will discharge the insurance company of obligations under the policy to the extent of the payment, and that I shall be responsible for charges not covered by this agreement.

GENERAL CONSENT TO TREATMENT: By signing below, I authorize MCHC staff and healthcare providers to perform any examination, tests and procedures and to provide any medications, treatment or therapy necessary to assess, diagnose and treat me. I understand that I may still refuse any particular examination, test, procedure, treatment, therapy or medication. I may also be asked to sign additional forms giving consent to specific types of treatments or procedures. I also understand that the practice of medicine is not an exact science and that no guarantees can be made to me as to the results of my evaluation and/or treatment.

Patient Signature: _____

Print Name: _____ Date: _____

Parent/Guardian Signature: _____

Print Name: _____ Date: _____

Witness Signature: _____