MCHC HEALTH CENTERS

PATIENT REGISTRATION

Patient Information:

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

Previous Last Name: _____ Sex : ☐ 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):

By answering the following questions, you will give us information we need to acquire funds to help uninsured and underinsured residents in our community. This information also helps us recognize clients who may qualify for specially funded programs or services.

Homeless: ☐ YES ☐ NO

If yes, currently living in: ☐ Shelter ☐ Street/Campground ☐ Transitional Housing
☐ Doubling Up (Family or Friend)

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

Veteran: ☐ YES ☐ NO

Race (Please check one) ☐ White (inc. Hispanic/Latino) ☐ Black/African American ☐ Asian
☐ American Indian/Alaska Native ☐ Native Hawaiian or Other Pacific Islander
☐ More than one race ☐ Decline to specify

Ethnicity (Please check one): ☐ Hispanic or Latino ☐ Non-Hispanic ☐ Unreported/Refused to report

Family Size: _____ Household Income: $_____ ☐ Annual ☐ Monthly

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 in 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: _____