



## **MCHC HEALTH CENTERS**

### **We respect your privacy and keep all information confidential!**

The questions we ask on the Patient Registration form are important. Our providers need information about your medical and surgical history, sexual orientation, race and other personal facts to make sure they provide care that addresses your individual risk factors and needs.

If you have any questions or concerns about the questions on the Patient Registration form, please discuss them with your nurse or medical provider when roomed.

Thank you.



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### **¡Respetamos su privacidad y mantenemos toda información confidencial!**

Las preguntas que hacemos en la forma de registro del paciente son importantes. Nuestros proveedores médicos necesitan información sobre su historia médica y quirúrgica, orientación sexual, raza y otros datos personales para asegurar que le proporcionen el cuidado adecuado con sus factores de riesgos individuales y sus necesidades.

Si usted tiene algunas preguntas o preocupaciones acerca de las preguntas en la forma de registro del paciente, por favor discútalas con su enfermera o médico cuando lo atiendan.

Gracias.



**PATIENT**

Last Name:

First Name:

MR#:

DOB:

Date:



**MCHC HEALTH CENTERS**

Form #CROSS-010-E

Rev. 01-20

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**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

**HILLSIDE HEALTH CENTER**  
 333 Laws Ave., Ukiah  
 (707) 468-1010  
 hillsidehealthcenter.org

**DORA STREET HEALTH CENTER**  
 1165 S. Dora St., Ste. A-1 & B-1, Ukiah  
 (707) 468-1015  
 dorastreethealthcenter.org

**LAKEVIEW HEALTH CENTER**  
 5335 Lakeshore Blvd., Lakeport  
 (707) 263-7725  
 lakeviewhealthcenter.org

**LITTLE LAKE HEALTH CENTER**  
 45 Hazel St., Willits  
 (707) 456-9600  
 littlelakehealthcenter.org

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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: \_\_\_\_\_

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**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: \_\_\_\_\_

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**INFORMATION: ADVANCE DIRECTIVES  
AND DO NOT RESUSCITATE ORDERS**

<p><b>What is an advance directive?</b></p>	<p>An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example). If you are admitted to the hospital, the hospital staff will probably talk to you about advance directives.</p> <p>A good advance directive describes the kind of treatment you would want for different levels of illness. For example, the directives would describe what kind of care you want if you have a critical illness, a terminal illness or permanent unconsciousness. Advance directives usually tell your doctor that you don't want certain kinds of treatment. However, they can also say that you want a certain treatment no matter how ill you are.</p> <p>Advance directives can take many forms. Laws about advance directives vary from state to state. You should be aware of your state laws regarding the scope and requirements that apply to advance directives.</p>
<p><b>What is a living will?</b></p>	<p>A living will is one type of advance directive. It only comes into effect when you are terminally ill. Being terminally ill generally means that you have less than six months to live. In a living will, you can describe the kind of treatment you want in certain situations. A living will doesn't let you select someone to make decisions for you.</p>
<p><b>What is a durable power of attorney</b></p>	<p>A durable power of attorney (DPA) for health care is like a living will, but it becomes active any time you are unconscious or unable to make medical decisions. In a DPA, you select a family member or friend who will be your medical decision-maker if you become unconscious or unable to make medical decisions. But a DPA may not be a good choice if you don't have another person you trust to make these decisions for you.</p> <p>Living wills and DPA's are legal in most states. Even if they aren't officially recognized by the law in your state, they can still guide your loved ones and doctor if you are unable to make decisions about your medical care. Ask your doctor, lawyer or state representative about the law in your state.</p>
<p><b>What is a do not resuscitate order?</b></p>	<p>A do not resuscitate (DNR) order is a request not to have cardio-pulmonary resuscitation (CPR) if your heart stops or if you stop breathing. (Unless given other instruction, hospital staff will try to help all patients whose heart has stopped or who have stopped breathing.) You can use an advance directive form or tell your doctor that you don't want to be resuscitated. In this case, a DNR order is put in your medical chart by your doctor. DNR orders are accepted by doctors and hospitals in all states.</p> <p>Most patients who die in a hospital have had a DNR order written for them. Patients who are not likely to benefit from CPR include people who have cancer that has spread, people whose kidneys don't work well, people who need a lot of help with daily activities, or people who have severe infections such as pneumonia that require hospitalization. If you already have one or more of these conditions, you should discuss your wishes about CPR with your doctor, whether in the doctor's office or when you go to the hospital. It's best to do this early, before you are very sick and are considered unable to make your own decisions.</p>

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<b>Should I have an advance directive?</b>	Most advance directives are written by older or seriously ill people. For example, someone with terminal cancer might write that she does not want to be put on a respirator if she stops breathing. This action can reduce her suffering, increase her peace of mind and increase her control over her death. You might want to consider writing an advance directive even if you are in good health. An accident or serious illness can happen suddenly, and if you already have a signed advance directive, your wishes are more likely to be followed.
<b>How can I write an advance directive?</b>	You can write an advance directive in several ways: <ul style="list-style-type: none"><li>• Use a form provided by your doctor.</li><li>• Write your wishes down by yourself.</li><li>• Call your state senator or state representative to get a form.</li><li>• Call a lawyer</li><li>• Use a computer software package for legal documents.</li></ul> Advance directives and living wills do not have to be complicated legal documents. They can be short, simple statements about what you want done or not done if you can't speak for yourself. Remember, anything you write by yourself or with a computer software package should follow your state laws. The orders should be notarized if possible, and copies should be given to your family and your doctor.
<b>Can I change my advance directive?</b>	You may change or cancel your advance directive at any time, as long as you are considered of sound mind to do so. Being of sound mind means that you are still able to think rationally and communicate your wishes in a clear manner. Again, your changes must be made, signed and notarized according to the laws in your state. Make sure that your doctor and any family members who knew about your directives are also aware that you have changed them.  If you do not have time to put your changes in writing, you can make them known while you are in the hospital. Tell your doctor and any family or friends present exactly what you want to happen. Usually, wishes that are made in person will be followed in place of the ones made earlier in writing. Be sure your instructions are clearly understood by everyone you have told.

*From The American Academy of Family Physicians*

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Form #HIM-002-E

Rev. 11-21

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**Acknowledgement of Receipt of Privacy Practices**

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of Mendocino Community Health Clinic (MCHC). Our Notice of Privacy Practices tells you how we may use and disclose your protected health information. We encourage you to read it in full.

We may change our Notice of Privacy Practices. If we change our notice, you may obtain a copy of the revised notice by accessing our website: <http://www.mchcinc.org/> by going to the Patient Privacy link at the bottom of the page or pick up a paper copy at any MCHC lobby. In addition, each time you register at or come to MCHC for treatment or health care services, a copy of the current notice in effect will be available to you.

I acknowledge receipt of Mendocino Community Health Clinic's Notice of Privacy Practices.

Patient' Name \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Patient/Legal Representative*

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