MHC Healthcare

MHC Healthcare Patient Registration

Patient Information

First Name_____ Mi _____ Last Name_____ Title _____

Address _____ City _____ State_____ Zip Code _____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

Date of Birth _____ Social Security Number_____ Sex: ( ) Male ( ) Female

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Employer Name _____ Occupation_____

Community Health Center Information

Email_____ **Veteran Status**: ( ) Veteran ( ) Non-Veteran

Annual Household Income ( ) $1,000-$10,000 ( ) $10,000-$25,000 ( ) $25,000-$50,000 ( ) $50,000-$75,000 ( ) $75,000+ Family Size_____

Emergency Contact_____ Phone # _____

Race: (Please check the one that applies)

( ) White ( ) Black/African American ( ) Native Hawaiian/Pacific Islander ( ) Asian ( ) American Indian/Alaska Native ( ) More than one race

Ethnicity: ( ) Hispanic ( ) Non-Hispanic ( ) Other

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

Responsible Party Information (if different than patient)

First Name_____ Mi _____ Last Name_____ Title _____

Address _____ City _____ State_____ Zip Code _____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

Date of Birth _____ Social Security Number_____ Sex: ( ) Male ( ) Female

Patients Relation To Responsible Party: ( ) Self ( ) Spouse ( ) Child ( ) Other_____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Employer Name _____

Primary Insurance Information

Insurance Name_____

Address _____ City _____ State_____ Zip Code _____

Policy #_____ Group#_____ Copay_$_____ Your Doctors Name_____

Subscriber Name_____ Mi _____ Last Name_____ Title _____

Address _____ City _____ State_____ Zip Code _____

Home Phone #_____ Work Phone #_____ Cell Phone #_____

Date of Birth _____ Social Security Number_____ Sex: ( ) Male ( ) Female

Patients Relation to Responsible Party: ( ) Self ( ) Spouse ( ) Child ( ) Other_____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed Employer Name _____

By signing this form I am consenting to Marana Health Center use and disclosure of my Protected Health Care Information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS for the purpose of carrying out treatment, payment and healthcare operations. I have been provided or offered a copy of Marana Health Center Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Marana Health Center for services rendered. By signing this form I am confirming that the above demographic and insurance information is current and correct. If the information is not correct I understand I will be held responsible for all charges incurred in today's visit

_____ _____ _____

Patient/Person giving consent Relationship if not patient Date