



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