MHC Healthcare
Quality healthcare with a heart!

MHC Healthcare COVID19 Test Registration

Patient Information

First Name _____ MI _____ Last Name _____

Address _____ City _____ State _____ Zip Code _____

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

Date of Birth _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Email _____

Race: (Please check 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 _____

Address _____ City _____ State _____ Zip Code _____

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

Date of Birth _____ Relationship _____

Primary Insurance Information

Insurance Name _____

Address _____ City _____ State _____ Zip Code _____

Policy # _____ Group # _____

Subscriber Name _____ MI _____ Last Name _____

Date of Birth _____ Sex: ☐ Male ☐ Female

Patients Relation to Responsible Party: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Employer Name _____

By signing this form I am consenting to Marana Health Center Inc.'s 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 Inc. Privacy Statement. I assign all medical and/or surgical benefits including major medical benefits to Marana Health Center Inc. 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**