MedNorth HEALTH CENTER

PATIENT REGISTRATION **Account #** _____
Ins Card(s) obtained: Y / N **Processed by:** _____

Name: _____ _____ _____
Last First Middle
Date of birth: _____/_____/_____ **Social Security # *(required)***: _____ **Sex**: ____M ____F

Street address: _____

PO Box: _____ **City:** _____ **State:** _____ **Zip code:** _____

Telephone Home/Cell: (____) _____ **Work**: (____) _____ **Email**: _____

Marital status: _____ **Student**: ☐ Full Time ☐ Part Time **Primary language**: _____

As a Federally Qualified Health Center, MedNorth is required to collect demographic information regarding the patients we serve. The information you provide is confidential. Please check Choose Not to Report if you do not wish to answer a specific question. Thank you for choosing MedNorth as your health care provider.

Race (check one) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ More than one race ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White/Caucasian ☐ *Choose not to report*

Ethnicity (check one) ☐Hispanic/Latino ☐Not Hispanic/Latino ☐ *Choose not to report*

Sexual Orientation:
☐ Straight (not lesbian or gay) ☐ Lesbian or gay ☐ Bisexual ☐ Something Else ☐ Don't Know ☐ *Choose not to disclose*

Gender Identity:
☐ Male ☐ Female ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to -Female ☐ Other ☐ *Choose not to disclose*

Are you a US Veteran? Yes No

Housing for patient or patient's parent/guardian, if a minor – Please check one
☐ Rent or own home ☐ Transitional ☐ Doubled Up (live with another person or family unit)
☐ Homeless Shelter ☐ Street ☐ Other _____ ☐ *Chose not to disclose*

Annual Family Income (Gross) - Please check one
☐$12,140 or below ☐$12,141 - $16,460 ☐$16,461 - $20,780 ☐$20,781 - $25,100 ☐$25,101 - $29,420 ☐$29,421 - $33,740
☐$33,741 – $38,060 ☐$38,061 - $42,380 ☐$42,381 – $46,700 ☐$46,701 - $51,020 ☐$51,021 - $55,340 ☐$55,341 - over
Family size: _____ ☐ *Choose not to disclose*

Patient's employer: _____ **Address**: _____

Spouse's name: _____ **Date of birth**:_____/_____/_____ **Spouse's Telephone:** (___) _____

Spouse's employer: _____ **Address**: _____

In case of **EMERGENCY**, we may contact: Name: _____ Telephone: (____) _____ Rel: _____

Guarantor Information: (Person who pays the bill?) Name: _____

Telephone: (____)_____Work phone: (____)_____Relationship_____

Address:_____City_____State_____Zip Code_____

Employer:_____Social Security number:_____Date of birth:_____/_____/_____

If Patient is a Minor: (Please complete this section)

Parent/Legal Guardian (1) Full Name: _____ **Telephone**: (_____) _____

Relationship to Patient: _____ **Date of Birth**: _____/____/____ **Work Phone**: (____) _____

Parent/Legal Guardian (2) Full Name: _____ **Telephone**: (_____) _____

Relationship to Patient: _____ **Date of Birth**: _____/____/____ **Work Phone**: (____) _____

***Non-Parent/Legal Guardian Designee** (authorized to accompany minor) **Full Name:** _____ **Relationship**: _____

(*IMPORTANT NOTICE: The information listed above is Not authorization and/or designation of a personal representative. A HIPAA release MUST be signed to discuss medical information.)

Is this visit due to an Accident/Injury: ☐ Yes ☐ No If yes, date of Injury: _____/_____/_____ ***WC / 3rd party liability form completed:* _____

☐ ***By checking this box, I acknowledge I do not have insurance or have a high deductible plan. I have been offered an application for the slide discount program (Caremed) and DO NOT want to participate.***

I certify that the information given above is true and correct.

_____ ____/_____/_____
(Patient Signature or Parent/Guardian signature, if patient a minor) (Date)

NOTE: Please present your insurance card and picture identification to patient registrar with this form.

(Rev 04/01/18)