Patient Registration Form

Thank you for choosing MedNorth Health Center!
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 Disclose if you do not wish to answer a specific question.

Last Name: ______________ **First Name:** ______________ **Middle Initial:** ______
Preferred Name: ______________ **Date of Birth:** ______________ **Social Security #:** ______________
Address or PO Box: ______________
City: ______________ **State:** ______ **Zip Code:** ______ **County:** ______________
Email: ______________ **Home Phone:** ______________ **Cell Phone:** ______________
Emergency Contact: ______________ **Relationship:** ______________ **Phone #:** ______________
If Patient is a Minor, Parent/Legal Guardian Name: ______________

Which services are you requesting? ☐ Medical ☐ Dental ☐ Integrated Health

PRIMARY LANGUAGE:
- ☐ English
- ☐ Spanish

Other: ______________

Country of Origin: ______________

Do you need an Interpreter?
- ☐ Yes
- ☐ No

MARITAL STATUS:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

EMPLOYMENT STATUS:
- ☐ Full Time
- ☐ Part Time
- ☐ Unemployed
- ☐ Retired

Employer: ______________

STUDENT STATUS:
- ☐ Full Time Student
- ☐ Part Time Student

ARE YOU A FARMWORKER?
- ☐ Yes, Migrant Farmworker
- ☐ Yes, Seasonal Farmworker
- ☐ No

ARE YOU A VETERAN?
- ☐ Yes
- ☐ No

ETHNICITY:
- ☐ Hispanic or Latino/a
- ☐ Non-Hispanic or Latino/a
- ☐ American Indian/Native American
- ☐ Asian
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Other: ______________

GENDER:
- ☐ Woman
- ☐ Man
- ☐ Transgender Man (F to M)
- ☐ Transgender Woman (M to F)
- ☐ Other: ______________
- ☐ Choose Not To Disclose

SEXUAL ORIENTATION:
- ☐ Straight (not Lesbian or Gay)
- ☐ Lesbian or Gay
- ☐ Bisexual
- ☐ Other: ______________
- ☐ Don't Know
- ☐ Choose Not To Disclose

NUMBER OF PEOPLE IN HOUSEHOLD:
Adults: ______
Children: ______

HOUSING STATUS:
- ☐ Rent Home/Apartment
- ☐ Own Home/Apartment
- ☐ Public Housing
- ☐ Shelter
- ☐ Street/Car
- ☐ Transitional Living
- ☐ Staying with family/friends
- ☐ Choose Not To Disclose

HOUSEHOLD INCOME RANGE:
- ☐ Less than $12,140
- ☐ $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
- ☐ Choose Not To Disclose

RESPONSIBLE PARTY INFORMATION

The responsible party is the person who will pay for the visit and is financially responsible for all bills.
Only complete this section if the responsible party and the patient are **not** the same person.

Relationship of Responsible Party: ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other: ______________
Name: ______________ DOB: ______________ SSN: ______________
Phone Number: ______________ Address or PO Box: ______________
City: ______________ State: ______________ Zip Code: ______________

______________________________ ______________
Patient Signature or Parent/Guardian Signature if Patient is a Minor Date

Patient Registration Form

Insurance Information

Please sign this form even if you are uninsured.

PRIMARY INSURANCE

Plan Name: ______________________ ID Number: ______________
Claims Address: ______________________ Group Number: ______________
Subscriber's Name: ______________________ Subscriber's DOB: ______________
Employer: ______________________ Effective Date: ______________
Subscriber's SSN: _____ - ____ - _____ Sex: ☐ M ☐ F Relationship to Patient: ______________

SECONDARY INSURANCE

Plan Name: ______________________ ID Number: ______________
Claims Address: ______________________ Group Number: ______________
Subscriber's Name: ______________________ Subscriber's DOB: ______________
Employer: ______________________ Effective Date: ______________
Subscriber's SSN: _____ - ____ - _____ Sex: ☐ M ☐ F Relationship to Patient: ______________

NOTICE TO PATIENTS:

MedNorth Health Center serves all patients regardless of the ability to pay. Discounts for essential services are offered based on family size and income. For more information, please inquire at the front desk or visit our website www.mednorth.org

PLEASE SIGN AND DATE BELOW, EVEN IF UNINSURED

Payment Policy: MedNorth Health Center requires payment on the day of service. This payment includes outstanding deductibles, co-payments, non-covered services, sliding fee payments and any charges remaining after insurance has made payment on your account. Please be advised that your insurance may not cover all charges and that you may be responsible for any balance on your account and will be billed until that balance is paid. The Sliding Fee Program is available for families with low incomes. This program allows patients to receive health at a discounted rate. You must apply with Patient Access Coordinators, providing documentation of total income and number of persons in the household. You must reapply for the program every year and payment must be made at time of service. Signing of this form indicates you are aware of above policies and procedures and were advised of the sliding fee program. I hereby authorize assignment of all insurance benefits payable directly to MedNorth Health Center.

______________________________ ______________________
Patient Name Date

______________________________ ______________________
Patient Signature or Parent/Guardian Signature if Patient is a Minor Date

REV. 5/09/2024