Patient Registration Form

Thank you for choosing MedNorth Health Center!

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:
- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Puerto Rican
- ☐ Hispanic, Latino/a, or Spanish Origin
- ☐ Not Hispanic, Latino/a, or Spanish Origin
- ☐ Choose Not to Disclose

RACE:
- ☐ American Indian/Alaska Native
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Asian Indian
- ☐ Filipino
- ☐ Chinese
- ☐ Japanese
- ☐ Vietnamese
- ☐ Korean
- ☐ Other Asian
- ☐ Guamanian or Chamorro
- ☐ Native Hawaiian ☐ Samoan
- ☐ Other Pacific Islander
- ☐ More than one race
- ☐ Choose Not To Disclose

GENDER:
- ☐ Male
- ☐ Female
- ☐ 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

IS THIS VISIT DUE TO AN ACCIDENT OR INJURY?
- ☐ Yes
- ☐ No
- ☐ If Yes, Date of Injury: _____

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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

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 care at a discounted rate. You must apply with Patient Access Coordinators, providing documentation of total income and the number of persons in the household. You must reapply for the program every year, and payment must be made at the time of service. Signing of this form indicates you are aware of the 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