

Monmouth Family Health Center Inc.

REGISTRATION FORM (PLEASE FILL OUT COMPLETELY)

PATIENT INFORMATION

TODAY'S DATE: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB: (M/D/Y): _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____

SOCIAL SECURITY #: _____ - _____ - _____ MARITAL STATUS: _____ SEX AT BIRTH: [] Male [] Female

HOME #: _____ MOBILE # _____ EMAIL: _____ [] OK to contact

DATA SURVEY - In an effort to comply with requirements regarding federal record-keeping and reporting, we ask that you complete the following data survey. Your cooperation is appreciated.

Sexual Orientation: [] Lesbian or gay [] Straight (not lesbian or gay) [] Bisexual [] Other [] Don't know [] Choose not to disclose [] Unknown
Gender Identity: [] Male [] Female [] Transgender Male/Female-to-Male [] Transgender Female/Male-to-Female [] Other [] Choose not to disclose

PRIMARY LANGUAGE: [] English [] Spanish [] Other: _____ INTERPRETER NEEDED?: [] Yes [] No

IS YOUR PRIMARY RESIDENT CONSIDERED PUBLIC HOUSING [] Yes [] No FAMILY SIZE: _____

ETHNICITY	RACE	SPECIAL POPULATION	ANNUAL INCOME RANGE
<input type="checkbox"/> Hispanic (Latino)	<input type="checkbox"/> Black (African-American)	<input type="checkbox"/> Migrant	<input type="checkbox"/> 0 - \$14,580
<input type="checkbox"/> Non-Hispanic (Not Latino)	<input type="checkbox"/> White	<input type="checkbox"/> Seasonal	<input type="checkbox"/> \$14,581 - \$21,870
<input type="checkbox"/> Unreported/Refused	<input type="checkbox"/> Asian	<input type="checkbox"/> Homeless Shelter	<input type="checkbox"/> \$21,871 - \$29,160
	<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Transitional	<input type="checkbox"/> \$29,161 - \$36,450
	<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Doubling Up	<input type="checkbox"/> \$36,451 - \$43,740
	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Street	<input type="checkbox"/> \$43,741 +
	Multiracial – select 2 from above	<input type="checkbox"/> Other	
	<input type="checkbox"/> Unreported	<input type="checkbox"/> Unknown	

RESPONSIBLE PARTY

SOCIAL SECURITY #: _____ - _____ - _____ RELATIONSHIP TO PATIENT: _____

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB (M/D/Y): _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____

HOME #: _____ MOBILE # _____ EMAIL: _____

INSURED INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____ DOB (M/D/Y): _____

EMPLOYER: _____ TELEPHONE #: _____

INSURANCE: _____ POLICY #: _____ GROUP #: _____ EFFECTIVE DATE: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____

INSURANCE TELEPHONE #: _____ RELATIONSHIP TO PATIENT: _____

I AUTHORIZE ASSIGNMENT OF BENEFITS FOR MEDICAL/DENTAL SERVICES TO BE PAID TO MONMOUTH FAMILY HEALTH CENTER: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY: _____ ST: _____ ZIP CODE: _____ PHONE #: _____

SIGNATURE: I certify that the information provided is correct: _____

MFHC USE ONLY - Patient Account #: _____ **Unit Clerk Initials:** _____ **Date:** _____