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:_____

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
□ Hispanic (Latino)	□ Black (African-American)	□ Migrant	□ 0 - $14,580
□ Non-Hispanic (Not Latino	□ White	□ Seasonal	□ $14,581 - $21,870
□ Unreported/Refused	□ Asian	□ Homeless Shelter	□ $21,871 - $29,160
	□ American Indian/Alaska Native	□ Transitional	□ $29,161 - $36,450
	□ Native Hawaiian	□ Doubling Up	□ $36,451 - $43,740
	□ Other Pacific Islander	□ Street	□ $43,741 +
	Multiracial – select 2 from above	□ Other	
	□ Unreported	□ 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 ASSIGMENT 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:_____