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 ASSIGNED 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
□ Hispanic (Latino)	□ Black (African-American)	□ Migrant	□ 0 - $15,060
□ Non-Hispanic (Not Latino	□ White	□ Seasonal	□ $15,061 - $22,590
□ Unreported/Refused	□ Asian	□ Homeless Shelter	□ $22,591 - $30,120
	□ American Indian/Alaska Native	□ Transitional	□ $30,121 - $37,650
	□ Native Hawaiian	□ Doubling Up	□ $37,651 - $45,180
	□ Other Pacific Islander	□ Street	□ $45,181 +
	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:______________