MAHUBE-OTWA FAMILY HEALTH

Patient Name

Patient # DOB

DEMOGRAPHIC/PATIENT REGISTRATION

Last Name:				**Address:**			
First Name:		**Middle Initial:**		**City:**			
Birth Date:		**Age:**		**State:**		**Zip Code:**	
Social Security# :				**County:**			
Biological Sex:	☐ Female ☐ Male			**What pronouns do you prefer?**			
Identify As:	☐ Female ☐ Male ☐ Transgender (FTM) ☐ Transgender (MTF) ☐ Genderqueer ☐ Other						
Employer(s):							
What race do you identify yourself as (mark all that apply)?	☐ White ☐ Am. Indian/Alaskan Native ☐ Black/African American ☐ Asian ☐ Nat. Hawaiian/Pacific Islander ☐ Other						
Are you of Hispanic, Latino or Spanish origin?	☐ Yes ☐ No						

May we send mail to the address above? ☐ Yes ☐ Yes, with anonymous return address ☐ NO, **If no, you are requesting not to receive mail for confidential reasons and you must provide us with an alternative address below where we may contact you:
Mahube-Otwa must be able to contact you by mail.

Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Remember to tell this person that you have given their address to Mahube-Otwa Family Health and mail may be sent there for you.

PATIENT PHONE NUMBER(S) **Please provide us with a phone number where we may contact you.**

Home:		Is it okay to call this number and leave a message for you: ☐ **Yes** ☐ **No**
Cell:		Is it okay to Text? ☐ **Yes** ☐ **No** Is it okay to call and leave a message? ☐ **Yes** ☐ **No**
May we Email you: ☐ **Yes** ☐ **No**		**Email:**

Emergency Contact Name:_____Phone:_____

Remember to tell this person that you have given their name/number to Mahube-Otwa Family Health. We will contact this person in the case of an emergency or if you, as the patient, are unreachable by preferred method of contact.

FINANCIAL INFORMATION **If you would like to see if you qualify for a discount, please fill out the following. Fees are based on income and family size. You are responsible for the charges for the services you receive.**

☐ **I prefer to not declare my income, and I agree to pay the full price for the services I receive.**

☐ **I have zero income – How do you support your living expenses? _____**

SOURCES OF INCOME: (include all pre-tax wages, including tips):	**Weekly Income**
Your Income from Employment	$
Age 21 or over and dependent of parent, your parent(s)/guardian income	$
Spouse/Domestic Partner's Income	$
CIRCLE OTHER INCOME: If you receive any of the following, list amount:	
Parental Support / Allowances	$
TANF / SSI / SSDI / General Assist. / EITC (earned income tax credit)	$
Soc. Sec. Retirement / Pension / Private Disability Insurance	$
Child Support / Alimony / Work Comp. / Unemployment	$
VA Disab. Compensation / VA Non-service Disab. Pension	$
Other:_____	$

HOURS PER WEEK _____

HOURLY WAGE $ _____

HOW MANY PEOPLE, INCLUDING YOURSELF DOES THIS INCOME SUPPORT? _____

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The following is used for statistical purposes: **Mahube-Otwa Family Health provides services without regard to race, color, religion, national origin, handicapping condition, age, sex, number of pregnancies, or marital status.**

Marital status:	☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Separated ☐ Widowed	
Education Level:	Current Student? ☐ Yes ☐ No	☐ 0-8 ☐ 9-12/Non-Graduate ☐ High School/GED ☐ 12+ Some Post-Secondary ☐ 2 or 4 year College Grad ☐ Grad of other post-secondary school
Describe your Household Type:	☐ Single Person ☐ Single Parent/Female ☐ Single Parent/Male ☐ Multi-generational House ☐ 2-Parent Household ☐ 2 Adults No Children ☐ Other ☐ Non-related Adults with Children	
What is your type of housing:	☐ Own ☐ Rent ☐ Homeless ☐ Other Permanent Housing ☐ Other	
Do you have children:	☐ No ☐ Yes Number of children born to you:	
Are you disabled:	☐ No ☐ Yes, please describe:	
My Health Insurance is: (Mark only one Primary Coverage)	☐ Medicaid ☐ Medicare ☐ State Children's Health Insur. Program ☐ State Health Insur. for Adults ☐ Military Health Care ☐ Direct-Purchase ☐ Employment Based ☐ Unknown ☐ None ☐ IHS	
Military Status:	☐ None ☐ Veteran ☐ Active Military	
Employment Status:	☐ Full Time ☐ Part Time ☐ Unemployed (not in labor force) ☐ Unemployed (short term, 6 months or less) ☐ Unemployed (long term, more than 6 months) ☐ Retired ☐ Migrant Seasonal Farm Worker	
Do you receive any Non-Cash Benefits:	☐ SNAP ☐ WIC ☐ LIHEAP ☐ HUD-VASH ☐ Housing Choice Voucher ☐ Public Housing ☐ Permanent Supportive Housing ☐ Childcare Voucher ☐ Affordable Care Act Subsidy ☐ Other (describe):_____	

If you are **ages 14-24**, are you : ☐ In School ☐ Working ☐ Both ☐ Neither

Where did you hear about us?	☐ Facebook	☐ Website	☐ Used before	☐ Friend	☐ Family	☐ Public Health Staff
	☐ School Staff	☐ Medical Clinic	☐ Theater	☐ Radio	☐ Newspaper	☐ Poster/Display
	☐ Web Search (Google ect.)		☐ Event	☐ Treatment Center	☐ Other - specify_____	

INSURANCE INFORMATION

☐ I WANT TO use my Insurance. *(If you checked this box, please fill out insurance information below and present all insurance cards to the Receptionist.)*

☐ I DO NOT WANT TO USE my insurance for confidentiality reasons and agree to be responsible for any applicable charges based on the sliding fee scale. *(Go to the Patient Agreement. Do not fill out the insurance information below.)*

☐ I DO NOT HAVE any insurance. *(Go to the Patient Agreement below. Do not fill out the insurance information below.)*

We would be happy to file your insurance claim for you. **Do you have Secondary Insurance ☐ Yes ☐ No**

Primary – Attach card for photocopying	*Secondary – Attach card for photocopying*
Relation to Patient: ☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Other	Relation to Patient: ☐ Self ☐ Father ☐ Mother ☐ Spouse ☐ Other
Name and Birth Date of Policy Holder:	Name and Birth Date of Policy Holder:

PATIENT AGREEMENT:

By signing this form and when using insurance, you are stating you AGREE with the following:

- *I understand I am responsible for charges for all services, including those not covered by my insurance or grant.*
- *I authorize the release of any medical or other information necessary to process a claim.*
- *I authorize the release of any medical records necessary for continuing care to another health care entity/provider.*
- *I authorize payment of medical benefits to Mahube-Otwa Family Health.*
- *I understand that services provided to me may appear on a statement of benefits to the policy holder (i.e. parents/spouse).*

Patient Signature: _____ Date: _____

THIS BOX FOR STAFF USE ONLY - TOTAL WEEKLY INCOME: $_____

STAFF USE ONLY: Code: _____ Insur. Type: _____ Apply MFPP: yes / no / has

LEP: YES NO Staff Initials: _____ Date: _____