



Patient Name	
Patient #	DOB

### DEMOGRAPHIC/PATIENT REGISTRATION

Last Name:		Age:		<input type="checkbox"/> Male	<input type="checkbox"/> Female
First Name:		Middle Initial:		Family Size:	
Birth Date:		Social Security# :			
Address:		County:			
City:		State:		Zip Code:	
Employer(s):					
What race do you identify yourself as (mark all that apply)?	<input type="checkbox"/> White	<input type="checkbox"/> Am. Indian/Alaskan Native	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Multi-Race	<input type="checkbox"/> Nat. Hawaiian/Pacific Islander
	<input type="checkbox"/> Asian	<input type="checkbox"/> Other			

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 will 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: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cell:		Is it okay to Text? <input type="checkbox"/> Yes <input type="checkbox"/> No    Is it okay to call and leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No
May we Email you: <input type="checkbox"/> Yes <input type="checkbox"/> 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):**

Your Income from Employment \$ \_\_\_\_\_

Age 21 or over and dependent of parent, your parent(s)/guardian income \$ \_\_\_\_\_

Spouse/Domestic Partner's Income \$ \_\_\_\_\_

Weekly Income
\$ _____
\$ _____
\$ _____

HOURS PER WEEK \_\_\_\_\_

HOURLY WAGE \$ \_\_\_\_\_

**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: \_\_\_\_\_ \$ \_\_\_\_\_

HOW MANY PEOPLE, INCLUDING YOURSELF DOES THIS INCOME SUPPORT? \_\_\_\_\_

**CIRCLE NON-CASH BENEFITS:** SNAP    WIC    LIHEAP    Childcare Voucher    Housing Choice Voucher    Affordable Care Act Subsidy  
Public Housing    Permanent Supportive Housing    HUD-VASH    Other \_\_\_\_\_



Patient Name	
Patient #	DOB

**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:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner
Are you of Hispanic, Latino or Spanish origin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Education Level:	Current Student? <input type="checkbox"/> Yes <input type="checkbox"/> No / <input type="checkbox"/> 0-8 <input type="checkbox"/> 9-12/Non-Graduate <input type="checkbox"/> High School/GED <input type="checkbox"/> 12+ Some Post-Secondary <input type="checkbox"/> 2 or 4 year College Grad <input type="checkbox"/> Grad of other post-secondary school
Describe your Household Type:	<input type="checkbox"/> Single Person <input type="checkbox"/> Single Parent/Female <input type="checkbox"/> Single Parent/Male <input type="checkbox"/> Multi-generational House <input type="checkbox"/> 2-Parent Household <input type="checkbox"/> 2 Adults No Children <input type="checkbox"/> Other <input type="checkbox"/> Non-related Adults with Children
What is your type of housing:	<input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Homeless <input type="checkbox"/> Other Permanent Housing <input type="checkbox"/> Other
Do you have children?	<input type="checkbox"/> No <input type="checkbox"/> Yes    Number of children born to you:
Are you disabled:	<input type="checkbox"/> Yes <input type="checkbox"/> No    Describe:
My Health Insurance is (Mark only one Primary Coverage)?	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insur. Program <input type="checkbox"/> State Health Insur. for Adults <input type="checkbox"/> Military Health Care <input type="checkbox"/> Direct-Purchase <input type="checkbox"/> Employment Based <input type="checkbox"/> Unknown <input type="checkbox"/> None <input type="checkbox"/> IHS
Military Status:	<input type="checkbox"/> None <input type="checkbox"/> Veteran <input type="checkbox"/> Active Military
Employment Status:	<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Unemployed (not in labor force) <input type="checkbox"/> Unemployed (short term, 6 months or less) <input type="checkbox"/> Unemployed (long term, more than 6 months) <input type="checkbox"/> Retired <input type="checkbox"/> Migrant Seasonal Farm Worker

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

If you are **less than age 18**, are your parent(s)/ guardian(s) aware of your visit today?     Yes     No

<b>Where did you hear about us?</b>	<input type="checkbox"/> Facebook <input type="checkbox"/> Website <input type="checkbox"/> Used before <input type="checkbox"/> Friend <input type="checkbox"/> Family <input type="checkbox"/> Public Health Staff <input type="checkbox"/> School Staff <input type="checkbox"/> Medical Clinic <input type="checkbox"/> Theater <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper <input type="checkbox"/> Poster/Display <input type="checkbox"/> Web Search (Google ect.) <input type="checkbox"/> Event <input type="checkbox"/> Treatment Center <input type="checkbox"/> 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.)

<b>We would be happy to file your insurance claim for you.</b>	<b>Do you have Secondary Insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary – Attach card for photocopying	Secondary – Attach card for photocopying
Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Spouse <input type="checkbox"/> Other	Relation to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Spouse <input type="checkbox"/> 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:** \_\_\_\_\_

**Your health is important to us.** If you have any questions or concerns, please call the clinic location or 877-275-6123.

<b>THIS BOX FOR STAFF USE ONLY - TOTAL WEEKLY INCOME: \$</b> _____
Minors Only: <input type="checkbox"/> Parent/Guardian unaware of visit. <input type="checkbox"/> Parent/Guardian is aware of visit

STAFF USE ONLY:    Code: \_\_\_\_\_    Insur. Type: \_\_\_\_\_    Apply MFPP: yes / no \_\_\_\_\_

LEP: YES    NO    Staff Initials: \_\_\_\_\_    Date: \_\_\_\_\_