MAHUBE-OTWA FAMILY HEALTH

Patient Name	
Patient #	DOB

DEMOGRAPHIC/PATIENT REGISTRATION

Last Name:				**Age:**		☐ **Male** ☐ **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)?	☐ White ☐ Am. Indian/Alaskan Native ☐ Black/African American ☐ Multi-Race ☐ Nat. Hawaiian/Pacific Islander ☐ Asian ☐ 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: ☐ **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? _____

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

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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 ☐ Separated ☐ Divorced ☐ Widowed ☐ Domestic Partner
Are you of Hispanic, Latino or Spanish origin?	☐ Yes ☐ No
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:	☐ Yes ☐ No 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

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

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: _____

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

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

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

LEP: YES NO Staff Initials: _____ Date: _____