MONMOUTH FAMILY HEALTH CENTER INC.

REGISTRATION FORM

PATIENT INFORMATION

Name: _____ Sex: ☐ F ☐ M Date: _____
Last First M

Address: _____ Date of Birth: (mm/dd/yyyy) _____
Street Apt #

Primary Phone #: _____ ☐ cell or ☐ home

_____
City State Zip

Alternate Phone #: _____ ☐ cell or ☐ home

Social Security #: _____ Marital Status: _____

In an effort to comply with requirements regarding federal record keeping and reporting, we ask that you please complete the following data survey. Your cooperation is appreciated. Thank you.

Primary Language: ☐ English ☐ Spanish ☐ Portuguese ☐ French ☐ Other _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unreported

Race: ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander
☐ American Indian/Alaska Native ☐ White
☐ Black/African American ☐ Unreported

(Please check more than one Race if more than one applies. Thank you.)

Place of Origin: _____
Interpreter needed: ☐ Yes ☐ No
Are you ***Employed***? ☐ Yes ☐ No ☐ Full time ☐ Pt time
Are you a ***Student***? ☐ Yes ☐ No
Are you a ***VETERAN***? ☐ Yes ☐ No

Annual Income: ☐ 0-$12,760 ☐ $12,761-$15,312 ☐ $15,313 - $17,864 ☐ $17,865-$22,968 ☐ $22,969-$25,520
☐ $25,521-$31,900 ☐ $31,901-$38,280 ☐ $38,281 or more **Family/Household size**: _____

RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____
Last First M

Address: _____ Date of Birth: _____
Street Apt #

Telephone #: _____

_____
City State Zip

Social Security #: _____ Cell #: _____

INSURED INFORMATION

Name: _____ Date of Birth: _____
Last First M

Employer: _____ Relationship to patient: _____

Insurance Co: _____ Policy #: _____

Address: _____ Group #: _____
Street Apt #

Effective date: _____

_____
City State Zip

Social Security #: _____ Telephone #: _____

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____
Last First Mi *Emergency contact*

Address: _____ Telephone #: _____

Name: _____ Relationship to patient: _____
Last First Mi *Other authorized individual*

Address: _____ Telephone #: _____

PATIENT CERTIFICATION and EMAIL RELEASE

I certify this information is correct: _____
Signature please

Your signature below will give us consent to communicate information via email about appointments (confirmations, updates and/or re-schedules), insurance application status, etc.

Email address (please print clearly above)	***Signature please***

Check here ☐ if you decline to provide an email address

DO NOT WRITE BELOW THIS LINE - - - - - - - FOR MFHC USE ONLY - - - - - - - DO NOT WRITE BELOW THIS LINE

Medical record #: _____ Clerk initials: _____

(Reg 04/2020)