



PATIENT REGISTRATION FORM

(Please Print Clearly)

PATIENT INFORMATION					
Patient's Last Name		First:		Middle:	
					Have You Been a Patient Here Before: <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Address:		Apt/Suite:		City:	
				State:	
Zip Code:					
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date:	Social Security #:	Phone Number:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other	
EMERGENCY CONTACT					
Name:		Relationship to Patient:		Address:	
				Phone Number:	
RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)					
Name:		Relationship to Patient:		Address:	
				Phone Number:	
INCOME INFORMATION					
Employer:			Employer Address:		
Income	Relationship	Age	Gross Monthly Income		Total Persons
					Total Gross Income
INSURANCE INFORMATION					
Is this Patient Covered by Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No (If you checked 'No' please skip this section)					
Please indicate Primary Insurance:		<input type="checkbox"/> Medicare <input type="checkbox"/> SCHIP <input type="checkbox"/> TN Care <input type="checkbox"/> Other _____			
Person Responsible for Charges:		Birth Date	Address: (if different):		Home Phone Number:
Subscriber's SSN:		Group Name:		Group Number:	Policy Number:
					Co-Payment: \$
Patient's Relationship to Subscriber:			<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
Secondary Insurance:	Subscriber's Name:	Subscriber's SS#:	Birth Date:	Group Number:	Policy Number:
Patient's Relationship to Subscriber:			<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		
Preferred Language:			Are You a Veteran of the Armed Forces:		Are You Homeless:
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Race:			Latino/Hispanic Descent:		
<input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Pacific Islander			<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> American Indian <input type="checkbox"/> More Than One Race <input type="checkbox"/> Unknown					
How Did You Hear about MHC? <input type="checkbox"/> Relative/Friend <input type="checkbox"/> School <input type="checkbox"/> Hospital <input type="checkbox"/> Church <input type="checkbox"/> Direct Mail <input type="checkbox"/> Internet					
<input type="checkbox"/> Magazine <input type="checkbox"/> Newspaper <input type="checkbox"/> Radio <input type="checkbox"/> A Step Ahead <input type="checkbox"/> CAAP <input type="checkbox"/> Health Fair/Community Event <input type="checkbox"/> Other: _____					
INSURANCE ASSIGNMENT					
I hereby authorize: (a) payment of insurance benefits otherwise due to me be made directly to Memphis Health Center (b) release of information, including protected health information to insurance companies as needed to file for payment services incurred; (c) Memphis Health Center to obtain records from other sources as may be necessary in the diagnosis or treatment and (d) understand that I am financially responsible to Memphis Health Center for charges related to services provided or incurred by me or the party I am responsible for.					
I certify that all statements made in this form are true, complete and accurate to the best of my knowledge. I understand that the sliding fee discount will expire six (6) months from this date.					
Signature _____			Date _____		