MOUNTAINLANDS COMMUNITY HEALTH CENTER
PATIENT REGISTRATION

PATIENT INFORMATION

DATE			
PATIENT'S NAME (First, Middle, Last)	ADDRESS	APT. #	
CITY AND STATE	ZIP CODE	SEX ☐ Female ☐ Male	
EMPLOYMENT STATUS ☐ Employed ☐ Part-time Student ☐ Full-time student	EMPLOYER/SCHOOL	HOME PHONE NUMBER	
WORK PHONE NUMBER (EXTENSION)	DATE OF BIRTH (Month/Day/Year)	SOCIAL SECURITY NUMBER	
MARITAL STATUS ☐ Single ☐ Married ☐ Other	NATIONALITY ☐ Hispanic ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Black (Non-Hispanic) ☐ Asian ☐ Other _____	WHO REFERRED YOU TO MCHC? ☐ Friend/Family Member ☐ ER ☐ Bill-board ☐ Health Department ☐ IHC/Non-ER ☐ Insta-Care ☐ Migrant Health Services ☐ Wasatch Mental Health ☐ Newspaper ☐ Mailer ☐ Other _____	
EMERGENCY CONTACT (Name, Relationship to Patient, Phone #)			
Preferred Language	Interpreter Required ☐ Yes ☐ No	LIST ANY INSURANCE(S)	

HEAD OF HOUSEHOLD

HEAD OF HOUSEHOLD	RELATIONSHIP TO PATIENT	MARITAL STATUS ☐ Single ☐ Married ☐ Other	
ADDRESS	CITY AND STATE	ZIP CODE	PHONE #
SOCIAL SECURITY NUMBER	SEX ☐ Female ☐ Male	DATE OF BIRTH (Month/Day/Year)	NATIONALITY ☐ Hispanic ☐ White ☐ American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Black (Non-Hispanic) ☐ Asian ☐ Other _____
EMPLOYER	WORK PHONE NUMBER		

Over the past 24 months, have you or a family member upon whom you are dependent (please circle):

Been hired to do seasonal agricultural work as the primary source of annual employment? YES NO

Moved in order to do agricultural work? If so, when _____ YES NO

and where _____ _____?
from to

Are you currently employed in agriculture as your primary source of income? YES NO

LIVING ACCOMODATIONS (Please choose one)

☐ Apt/House (***less*** then 12 months) ☐ Apt/House (***more*** than 12 months) ☐ Street ☐ Hotel/Motel
☐ Car ☐ Shelter ☐ Transitional Housing ☐ Substance Abuse/Treatment Center

I authorize Mountainlands Community Health Center (MCHC) to provide treatment for myself or any of my dependents. I also authorize MCHC to release all or part of the patient's record to any person or organization liable for payment. By signing this, I assign my insurance benefits to MCHC. I agree to pay for all charges not paid by the insurance company. If my account is sent to a collection agency, I agree to pay all attorneys' fees, court costs, filing fees, and all collection costs. I certify, that to the best of my knowledge, the above information is true, and that verification of said above information may be required at any time for any reason. If found ineligible, immediate termination of services and/or prosecution for fraud/perjury may occur.

Patient or Legal Guardian _____ Date _____ Witness _____

MEDICAL RECORD #: _____ DENTAL RECORD #: _____