MOUNTAINLANDS COMMUNITY HEALTH CENTER
PATIENT REGISTRATION/INFORMATION

PATIENT INFORMATION: Preferred Pharmacy: _____
Name and Location (City)

Patient Name:	Date of Birth:	Social Security Number:
Address:	City and State:	Zip Code:
Sex: ☐ Male ☐ Female	Home/ Cell Phone:	Email:

Marital Status: ☐ Single ☐ Married ☐Separated ☐ Divorced ☐ Widowed ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐White ☐American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Black (Non-Hispanic) ☐Asian ☐ Other_____☐Refused to report

Are you a Veteran of the US Armed Forces? ☐Yes ☐ No

Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student

Employer/School: _____ Work Phone: _____

Preferred Communication: ☐Patient Portal ☐ Phone ☐ Text ☐ Email ☐ Mail ☐ Fax to_____
☐ Other_____ ☐ Declined

Emergency Contact: _____
Name Relationship to Patient Phone Number

Preferred Language: _____ Do you have any Medical Insurance? ☐ No ☐ Yes _____
Insurance Company and Policy Number

HEAD OF HOUSEHOLD (if different from above): ***Relationship to Patient:*** _____

Name:	Date of Birth:	Social Security Number:
Address:	City and State:	Zip Code:
Sex: ☐ Male ☐ Female	Home/ Cell Phone:	Email:

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐White ☐American Indian/Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander ☐ Black (Non-Hispanic) ☐Asian ☐ Other_____☐Refused to report

Is Head of Household a Veteran of the US Armed Forces? ☐Yes ☐ No

Employment Status: ☐ Employed ☐ Part-time Student ☐ Full-time Student

Employer/School: _____ Work Phone: _____

I have read/reviewed MCHC HIPPA Policy. Initials: _____ Date: _____

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.

_____ _____ _____
Signature of Patient or Legal Guardian Date Witness (MCHC Employee)

Medical Record #_____ Dental Record #_____